

# ***Nebraska P&C Rate & Form Act***

***+ Rules + Appendices + Memos***

***including***

***The "Agents & Underwriters Manual"***

***Effective (fully) on 9/4/2005 when LB 119 becomes effective***

## **Please Read This First!**

In 2000, the Nebraska Legislature passed LB 1119, which completely revised P&C rate & form regulation in Nebraska. It included a substantial degree of commercial lines rate, form and surplus lines access “deregulation.” Following the passage of LB 1119, the Nebraska Department of Insurance promulgated three rules (Chapters 73, 74 and 75) to implement major portions of the new law. Since then, LB 444, LB 216 and LB 119, passed in 2001, 2003 and 2005, respectively, made additional changes to streamline the rate and form filing process. Department bulletin CB-50, which is not part of the sizable “package” that you have in front of you, addresses details relating to the rate and form filing process.

These law changes also changed aspects of the law that apply to agents and underwriters – those that use the products that insurers have filed to provide suitable coverage at appropriate prices to individual policyholders. As such, the package in front of you is designed as a reference for agents and senior underwriters – those people in the field that must identify what can and cannot be done under the new laws and rules in Nebraska. Its purpose is to pull together a daunting amount of detail and new information into a single usable document.

It is best to first study the 11-page document entitled, “Commercial P&C Rate & Form Deregulation in Nebraska.” This overview and the one-page Appendix 1 will give most people 90% of what they need to know, and it will create a context for understanding the three rules and the law itself, all of which are provided as appendices. After studying this overview, the reader can use the appendices to “drill down” when they require the detailed interpretations necessary to apply Nebraska’s rate & form laws to individual policyholders.

# **Commercial P&C Rate & Form Deregulation<sup>1</sup> in Nebraska**

## **– Explanations, Examples, Q&A's and Appendices**

In 2000, the Nebraska Unicameral passed LB 1119, a completely revised rate and form approval law incorporating varying degrees of deregulation for commercial P&C lines and policyholders. LB 1119 was codified as Article 75. Legislation passed in 2001, 2003 and 2005 made additional changes to this article and the Nebraska Department of Insurance has also promulgated several related rules. (In Nebraska bureaucratic parlance, a rule is known as a “chapter,” while a “chapter” of the law is an aggregation of “articles.” Thus, Chapters 73, 74 and 75 are rules, while Article 75 is a law that is part of Chapter 44. Confusing?) In addition to other items, a copy of this law (Article 75) and these rules (Chapters 73, 74 and 75) are attached to this document as appendices.

A major difference between the law prior to 2000 and the new law is that underwriters and agents will need to understand some of its major aspects. In the past, most of the people with the need to understand the rate and form law were tucked away at the home office in a state filings department. Under the new law, underwriters and agents will need to make determinations regarding the extent to which the insurer is obligated to follow its filed rates and forms. As such, underwriters and agents are the target audience for this user-friendly overview. While this document may also be of value to personnel in insurers' state filing departments, Bulletin CB-50 is directed to their needs (and is not discussed in this document).

An important caveat – this document does not have the legal status of a rule adopted by the Department of Insurance. It is an overview. If you have a problem or a question or a difficult determination – drill down using the most recent copies of the relevant rules and statutes. If there is an apparent conflict between this document and the rules or the statutes, then please check with the Department of Insurance. Either you're misinterpreting something or something needs to be corrected. In any event, if there is a conflict between this document and the rules or the statutes, rely on the rules and the statutes, because they will control.

### **Structure of this document**

This document will discuss nine subjects that relate to all commercial policyholders, including small policyholders that don't qualify as exempt commercial policyholders (ECPs). In a few instances, the discussions will be relevant to personal lines policyholders as well. Following that, the document will discuss ECPs. Appendices include charts and copies of relevant laws and regulations.

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<sup>1</sup> The term “deregulation” is misleading, yet it is used so commonly throughout the industry as well as by regulators that we shall use it here as well. The misleading aspect of the term is that almost nothing is fully deregulated. Rather, insurers and policyholders are offered varying degrees of freedom to do things that they couldn't do before, or which had previously required approval of the Department of Insurance. Thus, whenever you see the term “deregulation” in this document, consider it to refer to some lesser degree of regulation that now applies.

- A. Discussion of ten subjects relevant to non-ECPs:
- (1) Schedule rating has been replaced.
  - (2) Agency commission contribution as an individual risk rating factor – how it can and can't be used.
  - (3) The recognition of insurer groups has been eliminated.
  - (4) Experience rating is mandatory for eligible risks.
  - (5) The regulation of dividend rating plans has been eliminated.
  - (6) There is significant “deregulation” of forms for multi-state commercial insureds primarily located in a state other than Nebraska.
  - (7) Consent-to-rate provisions have been liberalized.
  - (8) Underwriters can do “one-time” customization of policy forms for most individual policyholders.
  - (9) Surety rates and forms are not subject to filing requirements.
  - (10) Warranty rates do not need to be filed; warranty forms except for auto warranty forms do not need to be filed.
- B. Discussion of exempt commercial policyholders (ECP's) – a reduction of regulatory requirements applying to rates, policy forms and surplus lines access.
- C. Appendices:
- (1) Table showing ECP qualification thresholds
  - (2) Chapter 73, a rule relating to ECPs
  - (3) Table showing the applicability of ECP status to lines of insurance
  - (4) Chapter 74, a rule that eliminates subjective rating factors
  - (5) Chapter 75, a rule relating to the applicability of form regulation to policyholders primarily located in another state
  - (6) Table showing the applicability of the rating law by line of insurance
  - (7) A discussion of Chapter 73 form deregulation for multi-state ECPs versus that provided by Chapter 75 for smaller multi-state policyholders
  - (8) Article 75, the P&C Rate and Form Act
  - (9) Copies of the laws referenced in Chapter 75.

## Section A

### Nine Subjects Relevant to Commercial Insureds Regardless of Size

**(1) Schedule rating has been replaced:** Schedule rating plans (a.k.a. “IRPM plans”) have been eliminated in Nebraska. Agents and underwriters may still see schedule rating plans sprinkled throughout insurer manuals, but they no longer apply in Nebraska<sup>2</sup>. To replace schedule rating, which provided insurers with  $\pm 25\%$  rating flexibility for most commercial lines, the law provides

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<sup>2</sup> In an effort to avoid unnecessary implementation problems, the Department didn't require that insurers physically refile their manual pages to remove references to schedule rating. Thus, these references will be seen in some manuals after January 1, 2001, even though they are no longer in effect. Over time, these references will be removed as insurers refile these manual pages for other reasons.

insurers with  $\pm 40\%$  rating flexibility for commercial lines of insurance, with limited exceptions. The most notable exception is that the  $\pm 40\%$  rating flexibility does not apply to insurance for farms and ranches, except that it does apply to workers' compensation insurance written for farms and ranches. See Appendix 6 for a detailed listing of those few commercial lines that are not "file and use" or to which  $\pm 40\%$  rating flexibility does not apply.

It is possible that the  $\pm 40\%$  range may be amended in the future based upon marketplace experience with its usage, but this will be a market-wide action and not something that an insurer can request via a rate filing. In fact, the  $\pm 40\%$  range doesn't need to be referenced in insurer manuals at all. It applies for all insurers whether their manuals mentions it or not.

Aside from the increased percentage flexibility, one may look at  $\pm 40\%$  rating flexibility in Nebraska law versus IRPM plans and ask, "What's the difference?" In practice, the answer will be "not much." Schedule rating ostensibly involved the consideration of separate "factors" like "management" and assigned various point values to each. In practice, it proved difficult for insurers to apply schedule rating plans in a textbook fashion. When applying the  $\pm 40\%$  range under the new law, insurers will be able to consider anything except "race, creed, national origin, or religion of the insured" or spouse abuse that would violate the Unfair Discrimination Against Subjects of Abuse in Insurance Act. It should also be noted that insurers are no longer be required to fill out any kind of schedule rating worksheets.

References: Chapter 74 is devoted to this subject. In the law, references include 44-7508(3); 44-7508(9)(a) & (f); 44-7509; 44-7510(3)(b) & (c), and 44-7511(9)(d).

**(2) Agency commission contribution as an individual risk rating factor:** IRPM plans often allowed insurers to reflect agency commission contribution as a rating factor. In much the same way that schedule rating plans have been replaced, this has been eliminated as well. References in rating manuals to recognition of agency commission contribution (often referred to as "expense reductions") no longer apply. The important caveat that keeps this from making much of a practical difference is that insurers can recognize commission contribution within the  $\pm 40\%$  rating range. But note that this flexibility is included within the  $\pm 40\%$  range, not in addition to it (as was often the case with schedule rating).

References: Section 006.01 of Chapter 74 specifically addresses this. In the statutes, references include 44-7508(9)(c) and 44-7511(9)(c).

**(3) The recognition of insurer groups has been eliminated:** Nebraska's law prior to 2000 was relatively unique in that it specifically recognized the existence of insurer groups when the group operated under common underwriting management. As such, insurer groups were routinely required to file the criteria necessary to identify which member insurer's pricing level would apply to any given policyholder. This put insurer groups on equal footing with single insurers (and vice-versa).

Under the new law, such "inter-insurer" criteria no longer need to be filed as part of the rating manuals (although "intra-insurer" program rules are still required). Inter-insurer references of this nature in rate manuals are no longer applicable, even if the insurer group has not specifically

withdrawn them. Insurer groups are free to place policyholders in any member company and use the rates on file for that member. Note that this applies to all P&C lines, not just commercial lines. Please note that it is not considered a nonrenewal when an insurer group moves a policyholder from one insurer to another affiliated insurer unless, “the transfer results in policy coverage or rates substantially less favorable to the insured.”

References: This interpretation exists owing to the lack of a reference in the law, but the background is stronger than that (which means that it would be especially difficult to make a contrary interpretation of the law). The prior law and the original bill draft both had provisions in them that recognized the existence of company groups, but these provisions were removed by an amendment on the floor of the Legislature that was specifically designed to remove this recognition.

**(4) Where filed, experience rating is mandatory:** The new law draws a clear distinction between (a) objective rating plans and criteria that are generally allowed, and (b) subjective rating criteria that are no longer allowed and have been replaced by a  $\pm 40\%$  rating range that applies to all insurers. But special mention needs to be made of experience rating plans.

When an experience rating plan is filed, it must be applied for all policyholders meeting an insurer’s filed minimum size and other objective requirements and for which credible<sup>3</sup> prior loss experience is available. Please note, however, that the Act makes specific allowances with regard to the determination of loss reserves used for experience rating, as it is unavoidable that these are subjective, whether the losses were incurred by the insurer that is doing the experience rating or by another insurer. In this respect, the law recognizes that the insurer must use its judgment with regard to the amount of loss reserves and also with regard to whether the information available from another source (i.e., a self-insured or the prior insurer) allows them to be credibly estimated at all.

References: Section 006.02 of Chapter 74 specifically addresses this. In the law, references include 44-7508(3); 44-7508(9)(b) & (f); 44-7510(3)(c); 44-7511(3), and 44-7511(9)(b) & (d).

**(5) Dividend plans:** Nebraska’s prior law was relatively unique in that it required the filing of dividend plans. This requirement has been removed under the new law. As such, past filings of these plans are no longer binding and insurers are free to add, delete or amend these plans as they see fit. The only requirement applying to dividend plans is that they are, in fact, plans that apply to dividends. Distinguishing characteristics that the Department will use as it examines payments represented to be dividends include:

- Dividends are not guaranteed;
- When paid, dividends must be declared by the board of directors and paid from unassigned surplus;

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<sup>3</sup> In this context, “credible” is not being used actuarially; rather, it means that the source of information appears to be trustworthy and believable. Depending on the circumstances, this may require a highly subjective judgment.

- Dividends are not credited or paid in advance;
- Dividends are not recouped based on subsequent loss development, and
- Dividends that would be otherwise payable are not made contingent upon renewal or upon the purchase of other insurance.

References: The lack of dividend regulation exists owing to the lack of a reference in the law, but the background is stronger than that (which means – as is also the case with changes relevant to insurer groups – that it would be especially difficult to make a contrary interpretation of the law). The prior law and the original bill draft both had provisions in them that recognized dividend rating plans, but these were removed by an amendment on the floor of the Legislature that was specifically designed to remove this recognition.

**(6) Treatment of forms used for multi-state commercial insureds primarily located in a state other than Nebraska:** One of the more unique aspects of the new Nebraska law is its treatment of forms issued to multi-state insureds that are primarily located in a state other than Nebraska. For the application of approved policy forms, multi-state insureds that are primarily located in Nebraska are treated the same as those that are solely located in Nebraska. However, subject to certain caveats, insurers may use forms that have not been approved in Nebraska for individual policyholders that are primarily located in another state. Please note that the law and the regulation that implement it do not relate to policyholder groups – the applicability of this liberalized treatment is determined on a policyholder-by-policyholder basis.

References: Chapter 75 addresses this subject specifically. In the law, see 44-7514. Appendix 7 discusses the apparent overlap between Chapter 73 (the ECP rule) and Chapter 75. Appendix 9 shows the affected Nebraska statutes.

**(7) Liberalized consent-to-rate provisions:** Nebraska’s law requires insurers to obtain a signature on a consent-to-rate application that details the unusual or extrahazardous condition, and submission to the Department is also required, but approval is generally<sup>4</sup> not required for either personal or commercial lines of insurance. Note that the law makes it possible for an insurer that regularly submits applications that do not reasonably list an unusual or extrahazardous condition to lose this “privilege” and be put on a prior approval basis.

**UNDERWRITERS AND AGENTS – PLEASE MAKE A SPECIAL NOTE OF WHAT THIS LAW CAN DO TO HELP YOU AND YOUR POLICYHOLDERS.** The purpose this relatively liberal provision is to eliminate a price-related regulatory barricade that sometimes pushed policyholders into the surplus lines market. It will be a success if underwriters and agents use it for its intended purpose.

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<sup>4</sup> The few exceptions include those very few lines of insurance, except medical professional liability, that are still on a prior approval basis for rates. But general commercial and personal lines, including workers’ compensation, medical professional liability and farm & ranch insurance, all fall under the liberalized consent-to-rate provisions.

References: In the law, see 44-7508(6) and 44-7511(6).

**(8) The ability of underwriters to customize policy forms for individual commercial insureds:** Individual policies may be customized on a one-time basis for both personal and commercial policyholders. That is, if an insurer crafts a manuscript policy and then wants to use it for a second policyholder, then it must be filed (although the filing can actually be done after the binding of coverage). Once the customized policy or endorsement has been developed, the insurer must provide the policyholder or prospective policyholder with a written listing of the unfilled forms and receive written acknowledgement back from the insured. This listing should be provided as soon as practical, but no later than 30 days after the effective date of the policy.

The significant exceptions to these provisions include workers' compensation insurance, excess workers' compensation insurance and medical professional liability insurance. This exemption is also limited in that it does not apply to any form that had been previously filed by the insurer with any department of insurance, whether approved or not. Thus, while it gives considerable flexibility on a one-time basis, it does not allow insurers to avoid the filing of forms generally. These provisions also do not apply to warranty-related contracts – see item (10) that follows.

Reference: In the law, see 44-7512(6).

**(9) Surety rates and forms are not subject to filing requirements:** Underwriters are free to develop such policies and contracts on an individual risk basis and to price them accordingly. The only trace of regulation for these lines is that contracts and loss costs developed by advisory organizations (e.g., the Surety Association of America) are still subject to filing and approval.

Reference: In the law, see 44-7505 as well as Appendix 6.

**(10) Warranty rates do not need to be filed; warranty forms except for auto warranty forms do not need to be filed:** The P&C Rate and Form Act has no provisions for the filing of rates or forms for any kind of warranty contracts. Another section of the insurance code provides that auto warranty forms must be filed prior to their use, however. The applicable law, which contains specific requirements for such contracts, requires the prior filing of all such forms on what might be viewed as a “file and use” basis.

Reference: In the law, see 44-3520 through 44-3526.

## **Section B**

### **Exempt Commercial Policyholders (ECP's)**

LB 1119 was a two-pronged revision to P&C rate and form regulation. The first prong was a revision of rate and form regulation generally. This included “file and use” filing requirements for commercial lines rates and some of the liberalizations already discussed in this document.

On a national basis, however, there was widespread recognition that the degree of regulation that is best for a small business will often prove counterproductive for a large business. Thus, in

many states, proposals for deregulation have been adopted that eliminate or modify the applicability of rate regulation, form regulation, or the requirements applying to surplus lines access. The second prong of LB 1119 addressed the need for deregulation of large policyholders in Nebraska, although it differs in details from the approaches taken in many other states.

The major differences between what Nebraska has done and what many other states have done include:

- Many other states placed thresholds for deregulation in their statutes. Nebraska's law provides guidance to the Department of Insurance to select the thresholds and adopt them by rule. Subject to certain statutory minimums, this allows the thresholds to be modified by the Department over time as experience indicates.
- Other states applied their entire "package" of deregulation – whatever it is – for rate, form and/or surplus lines access for policyholders over a particular size threshold. A policyholder that is just over the threshold gets the full package, while a policyholder just under the threshold gets none of the package (and thus is fully regulated). In Nebraska, the thresholds are applied stepwise – the lowest threshold applies for rate-only deregulation; a somewhat higher threshold applies for rate and form deregulation, and the highest threshold applies for rate, form and surplus lines deregulation.
- In Nebraska, a policyholder that is deregulated in another state in which it has more premium than in Nebraska is deregulated in Nebraska as well, as long as it meets the lowest possible minimum requirements under Nebraska's law (\$25,000 for rate deregulation, \$50,000 for form deregulation and \$100,000 for surplus lines deregulation).

The table shown as Appendix 1 provides a thumbnail overview of the thresholds contained in Chapter 73. (Chapter 73 makes reference to class R, RF and RFS policyholders. Deciphering these references, "class R" refers to rate-only deregulation, "class RF" is rate and form deregulation, and "class RFS" is rate, form and surplus lines access deregulation.)

### **ECP Points to Remember:**

1. **Types of insurance subject to ECP exemptions:** With only a few limited exceptions,<sup>5</sup> all commercial lines of insurance are subject to ECP exemptions (although the impact of policy form exemptions is restricted for certain lines of insurance). In addition, auto warranty contracts (which are regulated under a separate law) are not subject to ECP exemptions. Most insurance not subject to ECP provisions is seen to be personal in nature.
2. **Flexibility provided insurers for ECP's qualifying for policy form exemptions:** Insurers are encouraged to use standard policy forms and endorsements to the greatest extent possible, but are free to endorse or amend such policies as may be agreed upon between them and the policyholder. Insurers may develop completely unique policies for individual policyholders

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<sup>5</sup> See appendix 6 for a detailed listing of P&C lines that are "file and use" for rates versus those that remain on a "prior approval" basis.

when they are desired by the policyholder. The exceptions to these policywriting freedoms are as follow:

- Only approved policies and endorsements may be used to provide workers' compensation and excess workers' compensation coverage, except that the insurer may use unfiled endorsements that only amend policy provisions dealing with the remittance of premiums. Unfiled provisions may not be used to amend coverage or change the administration of claims handling.
  - Only approved policies and endorsements may be used to provide coverage for a medical professional liability policyholder that is using the policy to qualify under the Nebraska Excess Medical Liability Fund.
3. **Limitation on the discounts that may be applied:** An ECP cannot have its premiums discounted to less than the qualifying threshold. There will be situations for policyholders with premiums barely over the qualifying premium threshold where an insurer will have more downward rating flexibility by treating the policyholder as a non-ECP, and the insurer may do handle things that way if it desires.
  4. **Actual premiums are used to determine qualification:** In most circumstances, all P&C premiums for the policyholder may be used to determine ECP qualification, regardless of whether the premiums arise from Nebraska exposures or exposures elsewhere and regardless of whether the rates for the type of insurance are normally subject to rate filing requirements. The premiums used are the actual premiums for the prospective policy term for the insurer that is offering to provide coverage. Chapter 73 explains procedures when premiums are retrospectively rated (use a guaranteed cost estimate); when premiums are based on auditable exposures (use a best estimate); when another insurer writes some of the coverages (use last year's premium if provided), and when policies don't have common anniversary dates (use the current in-force premium). The only premiums that are excluded are those that the insurer isn't writing and the policyholder isn't sharing information. In such a situation, the insurer is not allowed to use a guess or an estimate of what the premiums will be.
  5. **Combining unrelated entities for ECP qualification:** Premiums for entities that are not under common ownership may not be combined to qualify a group as an ECP. There is no such thing as a "group ECP" under Nebraska law.
  6. **Statistical considerations:** The object of the law is to provide policyholders with coverage for the most appropriate premium charge, without any sort of regulatory restriction. If the manual rate for a given exposure is \$0.50, then the insurer can use \$0.08 or \$2.50 or whatever else makes best sense in view of competitive considerations and expected losses and expenses for that exposure. What we seek to avoid – and what the rule prohibits – is the writing of individual coverages for arbitrary premium amounts, unrelated to expected losses, with the only consideration being an appropriate total account premium.

We recognize that a long-time problem with rate regulation has been that insurers are often coerced by the marketplace to offer greater-than-indicated discounts for policies where they

have rating flexibility in order to offset for other policies where they cannot apply the discount that they feel is appropriate. Now that insurers will have no restrictions to keep them from pricing each coverage appropriately, we expect them (and the rule requires them) to provide rational premiums on a policy-by-policy and exposure-by-exposure basis. Proper allocation of premium taxes and effective evaluation of statistical data would not be possible if insurers engage in arbitrary allocations of premiums that are unrelated to the insurer's assessment of the risk.

7. **Responsibility to determine ECP qualification:** When ECP qualification depends on information other than information (like proposed premiums) already contained in an insurer's files, the insurer must obtain a written statement from the insured (a statement from the agent is not sufficient) to document the necessary missing facts regarding its qualifications. An insurer is not compelled to do any further checking with regard to an insured's qualifications unless the information available to it makes it appear unlikely that the insured's representations are accurate.
8. **Continued use of unapproved forms for an ECP that no longer qualifies:** An insurer may renew using unapproved forms for an entity that no longer qualifies for ECP forms exemption if the unapproved forms were originally agreed to during a period of time for which the policyholder qualified for an ECP forms exemption, but only if the policyholder continues to have total premiums of at least \$50,000.

This is complex, because it might still be possible for smaller policyholders to use some unapproved forms based on non-ECP provisions in the insurance law. See item 8 on page 6 of this document. Presumably, this situation should be rare.

9. **Nature of the surplus lines exemption:** One purpose of ECP exemptions is to free licensed insurers from the restrictions that have encouraged some large policyholders to seek coverage from the surplus lines market. Nothing contained in this rule should be construed as encouraging large policyholders to seek coverage in surplus lines markets.

The surplus lines exemption for qualifying ECP's allows the policyholder to purchase insurance from a surplus lines insurer even though licensed insurers may be willing to write identical coverage at reasonable rates. There is no need to demonstrate that coverage is unavailable from licensed insurers. Surplus lines coverage must still be purchased, however, through a licensed surplus lines agent. Surplus lines coverage may not be purchased for workers' compensation, excess workers' compensation or automobile liability insurance (except excess limits auto liability policies). As a practical matter, although not dictated by the rate & form act or rules, surplus lines coverage won't work for medical professional liability policies used to qualify a health care provider for the Nebraska Excess Liability Fund, because the policies won't be accepted by the Excess Fund.

10. **Continued use of a surplus lines insurer by an ECP that no longer qualifies:** A similar provision to that discussed in item 8 applies when an ECP no longer qualifies to purchase coverage through a surplus lines insurer without the requirement to first demonstrate that

coverage is not available from a licensed insurer. The policyholder may renew coverage with a surplus lines insurer as long as its total premium remains at least \$100,000.

11. **Policy form deregulation for ECP's primarily located in another state:** The policy form deregulation for ECP's primarily located in another state is more sweeping than the policy form deregulation that applies to Nebraska-based ECP's. (This same degree of policy form deregulation also applies to non-ECP's that are primarily located in another state.) As such, Chapters 73 and 75 have "carve outs" for such ECP's so that they are not inadvertently made subject to greater policy form regulation than they would be if they were not ECP's. See Appendix 7 for a thorough discussion devoted to this point.

### **ECP Questions & Answers**

- Q: I have a Nebraska policyholder (without a qualifying risk manager) that has a manual CMP premium of \$75,000 and a manual WC premium of \$125,000. What is the lowest total account premium that I can charge?
- A: \$75,000, as the insured would no longer be an ECP with a lower premium. If the policyholder had a qualifying risk manager, then the answer would be \$25,000.
- Q: I have a Nebraska policyholder with a manual CMP premium of \$75,000 and a manual WC premium of \$125,000. I'm shooting for a total account premium of \$120,000. Can I bump the CMP premium up to, say, \$100,000 and charge \$20,000 for the WC policy on account of the fact that the premium taxes are lower on the CMP than on the WC?
- A: No. The premiums for each policy and state must reflect the expected costs of insuring the exposures on that policy and in that state. Each policy does not necessarily need to receive precisely the same percentage discounts, but the premiums can't be manipulated for tax or other purposes.
- Q: I have a Nebraska policyholder without a qualifying risk manager for which the non-WC premiums should be about \$225,000. Can we bump the premium up a bit to \$250,000 and thus qualify the policyholder for forms exemption?
- A: Yes, you can, but that would almost certainly be a disservice to the policyholder. Provisions applying to non-ECPs allow most necessary tailoring of coverage. (See item 8 on page 6.) The forms-eligible ECP has only a little more flexibility – an insurer can use forms for an forms-eligible ECP that have been disapproved by the Department, where that can't be done for a non-ECP.
- Q: I have a Nebraska policyholder with an inland marine exposure (premiums run about \$40,000) where the rates are not subject to filing requirements, plus other filed-rate coverages with relatively low premiums (about \$30,000). Is there some way that I can gain a competitive advantage by manipulating the inland marine premiums to make this policyholder an ECP?

A: No. A policyholder that qualifies as an ECP based on premiums can't (based on its ECP qualification) have its premiums discounted to less than the qualifying threshold. (In practicality, this is probably not a very good example, because the insurer would have considerable flexibility owing to a large inland marine exposure with unfiled rates.) But it makes the necessary point.

Q: Are there any qualifications or requirements relating to a “qualifying risk manager”?

A: Yes. See section 003.07 of Chapter 73.



**Deregulation for (1) Rates; for (2) Rates and Forms; and for (3) Rates, Forms and Surplus Lines Access  
(Qualification is a function of size and whether a risk manager is employed.)**

	(1) Rates	(2) Rates and forms	(3) Rates, forms and surplus lines access	(3) Rates, forms and surplus lines access
<b>Which characteristics must apply →</b>	<b>At least \$25,000 in annual P&amp;C insurance premiums plus one of the below</b>	<b>At least \$50,000 in annual P&amp;C insurance premiums plus one of the below</b>	<b>At least \$100,000 in annual P&amp;C insurance premiums plus one of the below</b>	<b>At least \$100,000 in annual P&amp;C insurance premiums, a qualifying risk manager, plus at least two of the below</b>
<b>↓ Qualifying Characteristics ↓</b>				
Annual aggregate P&C insurance premiums at least	\$75,000 (excluding medical professional) or \$250,000 (including medical professional)	\$250,000 (excluding WC and medical professional) or \$1,000,000 (including WC and medical professional)		\$250,000 (excluding WC and medical professional) or \$1,000,000 (including WC and medical professional)
Deregulation in a state where the risk has more premiums than in Nebraska.	Deregulated for rates or forms in a state where the risk has more premiums than in Nebraska	Deregulated for rates and forms in a state where the risk has more premiums than in Nebraska**	Deregulated for rates, forms and surplus lines access in a state where the risk has more premiums than in Nebraska	
Net worth at least				\$25,000,000
Annual net revenues or sales at least				\$50,000,000
Number of employees at least				250
Not-for-profit or governmental annual budget of at least				\$25,000,000
Risk manager	Qualifying risk manager*	Qualifying risk manager*		

\* There are significant experience and qualification requirements for a person to be considered a qualifying risk manager. The agent for the policyholder – no matter how well qualified – does not constitute a “qualifying” risk manager. A “qualifying” risk manager, in addition to being “qualified,” must also be independent of the agent(s) and insurer(s) providing coverage. See section 003.07 of Chapter 73 for the details.

\*\* This is not straightforward. Other provisions of LB 1119 dealing with multi-state policyholders effectively provide form deregulation for policyholders of any size, with or without a risk manager, if they are primarily located in another state in which they are deregulated for forms. Chapter 75 is the rule that implements this. See Appendix 7 for a fuller discussion. In general, although this provision in the ECP rule may apply to an occasional policyholder, Chapter 75 will be the rule most commonly used by insurers for policyholders primarily located in another state.

In practice, we anticipate that very few risks will qualify for rate deregulation with less than \$75,000 in premium or form deregulation with less than \$250,000 in premium. We don’t think that the other means of qualification (risk manager or deregulation in another state) will be common.



## Chapter 73

### EXEMPT COMMERCIAL POLICYHOLDERS

#### 001. Purpose and scope.

001.01 The purpose of this chapter is to implement sections 15 and 16 of LB 1119, passed in the 2000 session of the Nebraska Legislature and codified at Neb.Rev.Stat. §§ 44-7515 and 44-7516, which require the director of insurance to adopt rules that:

- (1) Modify or eliminate requirements for insurers to use filed rates and approved policy forms for commercial lines property and casualty insurance sold to certain commercial policyholders under common ownership; and
- (2) Allow certain exempt commercial policyholders to be exempt from those provisions of Neb.Rev.Stat. §§ 44-5510 and 55-5511 that require, as a condition for the purchase of insurance from a nonadmitted insurer, that the applicant demonstrate an inability to obtain insurance from a licensed insurer.

001.02 This chapter includes rate filing and form approval and surplus lines access exemptions for the lines, types and classes of commercial lines property and casualty insurance filed pursuant to Neb.Rev.Stat. § 44-7508, and workers' compensation insurance, medical professional liability insurance, and insurance covering farms and ranches, including crop insurance.

002. Authority. This Rule is promulgated under the authority vested in the Director by Neb.Rev.Stat. §§ 44-101.01, 44-7515, and 44-7516.

003. Definitions. For the purposes of Chapter 73, the following definitions apply.

03.01 The definitions set forth in Neb.Rev.Stat. § 44-7504 apply for purposes of this chapter.

03.02 "Class RFS policyholder" means an exempt commercial policyholder that fulfills either of the two following sets of conditions:

- (1) (A) The policyholder utilizes the services of a qualifying risk manager;
- (B) The policyholder generates at least \$100,000 in aggregate commercial lines property and casualty insurance premiums per year, and

- (C) The policyholder meets at least two of the following conditions:
  - (i) The policyholder generates aggregate commercial lines property and casualty insurance premiums of at least \$250,000 per year, excluding premiums for workers' compensation and medical professional liability insurance, or generates at least \$1,000,000 aggregate commercial property and casualty insurance premiums per year, including premiums for workers' compensation and medical professional liability insurance.
  - (ii) The policyholder's net worth is at least \$25,000,000.
  - (iii) The policyholder's annual net revenues or sales are at least \$50,000,000.
  - (iv) The policyholder employs at least 250 employees.
  - (v) If the policyholder is a not-for-profit or government entity, the policyholder has an annual operating budget of at least \$25,000,000.
- (2) (A) The policyholder generates at least \$100,000 in aggregate commercial lines property and casualty insurance premiums per year for all jurisdictions combined, and
- (B) In a jurisdiction that generates greater aggregate commercial property and casualty insurance premiums for the policyholder than Nebraska:
  - (i) No rates for the policyholder are subject to a requirement that the insurer adheres to its rating manuals;
  - (ii) No policy forms for the policyholder, other than policy forms for workers' compensation and automobile liability insurance, are subject to a requirement that the insurer must use filed forms, and
  - (iii) Access to surplus lines markets for other than workers' compensation and automobile liability insurance for the policyholder is not subject to any requirement that such coverage is not available from a licensed insurer.

003.03 “Class RF policyholder” means an exempt commercial policyholder that meets any one of the three following sets of conditions:

- (1) The policyholder utilizes the services of a qualifying risk manager and generates at least \$50,000 in aggregate property and casualty insurance premiums per year.
- (2) The policyholder generates aggregate commercial lines property and casualty insurance premiums of at least \$250,000 per year, excluding premiums for workers’ compensation and medical professional liability insurance, or generates at least \$1,000,000 per year in aggregate property and casualty insurance premiums, including premiums for workers’ compensation and medical professional liability insurance.
- (3) (A) The policyholder generates at least \$50,000 in aggregate commercial lines property and casualty insurance premiums per year for all jurisdictions combined, and
  - (B) In a jurisdiction that generates greater aggregate commercial property and casualty insurance premiums for the policyholder than Nebraska:
    - (i) No rates for the policyholder are subject to a requirement that the insurer adhere to its rating manuals, and
    - (ii) No policy forms for the policyholder, other than policy forms for workers’ compensation and automobile liability insurance, are subject to a requirement that the insurer must use filed forms.

003.04 “Class R policyholder” means an exempt commercial policyholder that meets any one of the three following sets of conditions:

- (1) The policyholder utilizes the services of a qualifying risk manager and generates at least \$25,000 in aggregate commercial lines property and casualty insurance premiums per year.
- (2) The policyholder generates aggregate property and casualty insurance premiums of at least \$75,000 per year excluding premiums for medical professional liability insurance, or generates at least \$250,000 in aggregate commercial lines property and casualty insurance premiums per year, including premiums for medical professional liability insurance.
- (3) The policyholder generates at least \$25,000 in aggregate commercial lines property and casualty insurance premiums per year for all jurisdictions combined and, in a jurisdiction that generates greater aggregate

commercial property and casualty insurance premiums for the policyholder than Nebraska, rates for the policyholder are not subject to a requirement that the insurer adheres to its rating manuals.

003.05 “Commercial lines property and casualty insurance” means property and casualty insurance filed pursuant to Neb.Rev.Stat. § 44-7508, and also includes workers’ compensation insurance, medical professional liability insurance, and insurance covering farms and ranches, including crop insurance.

003.06 “Exempt commercial policyholder” means a Class RFS, RF, or R policyholder, as defined by this chapter, that may purchase insurance policies for which specific aspects of rate or policy form regulation do not apply or have been relaxed, or that is exempt from those provisions of §§ 44-5510 and 44-5511 that require, as a condition for the purchase of insurance from a nonadmitted insurer, that applicants demonstrate inability to obtain insurance from a licensed insurer.

003.07 “Qualifying risk manager” means:

- (1) (A) A person that is a full time employee of the policyholder with primary duties consisting of property and casualty risk management and the purchase of insurance, and that meets the qualification standards in paragraph (2); or
- (B) A person or persons, operating as a contractor that primarily provides risk management services, that devotes at least one hundred twenty hours per year to the policyholder’s risk management and purchase of insurance. No such person shall be an agent for an insurer providing insurance for the policyholder, and shall not receive any compensation from an insurer, or from an agent of an insurer that is providing insurance for the policyholder, or from an agency compensated by the insurer that is providing insurance for the policyholder. Each person whose hours are included in the total hours necessary to meet this requirement is required to meet the qualification standards in paragraph (2).
- (2) Who has demonstrated qualification through:
  - (A) Five or more years of full time experience in property and casualty insurance as a commercial lines underwriter with an insurance company or as an insurance producer dealing primarily with commercial accounts, except that health and employee benefit experience shall not count towards this requirement; or
  - (B) Three years of full-time experience related to property and casualty insurance or risk management and attainment of one of the following insurance professional designations:

- (i) Associate in Risk Management;
- (ii) Certified Risk Manager; or
- (iii) Chartered Property Casualty Underwriter.

003.08 “Workers’ compensation insurance” means workers’ compensation insurance, as defined in Neb.Rev.Stat. § 44-201 (11), and includes insurance written with deductibles. “Workers’ compensation insurance” does not include excess workers’ compensation insurance provided for policyholders that have qualified with the Nebraska Workers’ Compensation Court as approved self-insureds.

004. Exemptions applicable to policies of insurance sold to exempt commercial policyholders.

004.01 Exemptions applicable to Class RFS policyholders.

- (1) As permitted by Neb.Rev.Stat. § 44-7515, an insurer shall not be required to use filed rates and approved policy forms for commercial lines property and casualty insurance policies insuring Class RFS policyholders. The provisions of this chapter regarding the regulation of policy forms shall not apply to an exempt commercial policyholder that is also a qualifying multistate commercial policyholder as defined pursuant to Chapter 75.
- (2) As permitted by Neb.Rev.Stat. § 44-7516, a Class RFS policyholder is exempt from those provisions of §§ 44-5510 and 44-5511 that require, as a condition for the purchase of insurance from a nonadmitted insurer, that applicants demonstrate inability to obtain insurance from a licensed insurer. This exemption shall not apply to workers’ compensation insurance, excess workers’ compensation insurance, or automobile liability insurance. This exemption may apply to automobile liability insurance purchased as excess insurance over a policy that provides limits that are at least equal to the minimum limits of liability required by Neb.Rev.Stat. § 60-534.

004.02 Exemptions applicable to Class RF policyholders. As permitted by Neb.Rev.Stat. § 44-7515, an insurer shall not be required to use filed rates and approved policy forms for commercial lines property and casualty insurance policies insuring Class RF policyholders. The provisions of this chapter regarding the regulation of policy forms shall not apply to an exempt commercial policyholder that is also a qualifying multistate commercial policyholder as defined pursuant to Chapter 75.

004.03 Exemptions applicable to Class R policyholders. As permitted by Neb.Rev.Stat. § 44-7515, an insurer shall not be required to use filed rates for commercial lines property and casualty insurance policies insuring Class R policyholders.

005. Status as an exempt commercial policyholder is optional. An insurer or policyholder that does not desire to avail itself of the provisions of this regulation is not required to make a determination of exempt commercial policyholder status. Such a policyholder shall be accorded the same treatment as a policyholder that does not qualify as an exempt commercial policyholder. In addition, the provisions of this chapter regarding the regulation of policy forms shall not apply to an exempt commercial policyholder that is also a qualifying multistate commercial policyholder as defined pursuant to Chapter 75.

006. Unrelated entities may not be combined to attain exempt commercial policyholder status. Premiums or other attributes for entities that are not under common ownership may not be combined to qualify a policyholder as an exempt commercial policyholder.

007. Premiums used to determine exempt commercial policyholder status.

007.01 Calculation of premium amounts. For purposes of determining whether a policyholder is a Class RF, RFS or R policyholder, premiums shall include all commercial lines property and casualty insurance premiums generated by a policyholder on risks located in Nebraska and elsewhere, without regard to whether such insurance is purchased from one or more insurers. Such premiums shall be those offered by an insurer for the prospective policy term. If an insurer is not offering all of the commercial lines property and casualty insurance that an exempt commercial policyholder is purchasing, premiums for expiring policies for which the insurer is not offering insurance shall be used as the basis for premium determination. If not all policies for a policyholder have a common inception date, premium for policies that are in force as of the inception date of coverage for which the calculation is made shall be used. For policies that the insurer does not write, the insurer shall only use premiums for which policyholder documentation is provided. If an insurer is not provided with policyholder documentation of the premiums for policies that the insurer does not write, then the insurer shall not include premiums for such policies to determine whether a policyholder is a Class RF, RFS, or R policyholder.

007.02 Retrospectively determined premium. For purposes of determining whether a policyholder is a Class RF, RFS or R policyholder, if a policy's premium will be determined retrospectively, then it shall be calculated as if the policyholder were rated on a guaranteed cost basis. Exempt commercial policyholder status shall not be retroactively denied if actual losses incurred under the policy result in an actual premium lower than the estimated premium calculated on a guaranteed cost basis.

007.03 Premium based on auditable exposures. For purposes of determining whether a policyholder is a Class RF, RFS or R policyholder, if a policy's premium is determined based on exposures that are subject to audit as defined in the policy, then it shall be calculated using a good faith estimate of exposures. Exempt commercial policyholder status shall not be retroactively denied if the audited exposures result in a premium that is lower than the estimated premium.

008. Restrictions on rate filing exemptions.

008.01 Nebraska premiums must arise from Nebraska exposures. The Nebraska premiums for each individual policy and for each separately coded exposure under that policy shall be the amounts that most closely correspond with the insurer's evaluation of the expected losses and expenses that will be generated by each exposure and policy. Premiums for Nebraska exposures shall not be discounted or surcharged based on a policyholder's premiums for exposures in another state that are higher or lower than are desired by the insurer.

008.02 Restrictions on permissible discounts. Rate credits for an exempt commercial policyholder may not be used to reduce the policyholder's premium to less than the amount necessary for the policyholder to qualify as an exempt commercial policyholder. Nothing in this subsection shall require reduction of rate credits if the premium for a retrospectively rated policy or for a policy with premium based on auditable exposures is ultimately lower than was originally estimated.

008.03 Restrictions on permissible surcharges. An insurer may not impose a surcharge against a policyholder exceeding the surcharge permissible under Neb.Rev.Stat. § 44-7509, unless the aggregate property and casualty insurance premiums for such policyholder, prior to the application of any surcharge permissible under Neb.Rev.Stat. § 44-7509, exceed the minimum aggregate property and casualty insurance premium threshold to qualify as an exempt commercial policyholder.

008.04 Workers compensation. As required by Neb.Rev.Stat. § 44-7524, every insurer writing workers' compensation shall adhere to the uniform workers' compensation classification system and shall report its workers' compensation experience in accordance with statistical plans and other reporting requirements to ensure that workers' compensation data is combined for all insurers for the development of prospective loss costs and the application of experience rating. This includes the requirement that premiums are determined from audited payrolls instead of being written on a guaranteed cost basis, not subject to audit.

009. Restrictions on form approval exemptions.

009.01 Workers' compensation and excess workers' compensation. As permitted by Neb.Rev.Stat. § 44-7515 (2) and as set forth in Neb.Rev.Stat. § 44-7515 (6), only policy forms and endorsements approved by the director may be used to provide workers' compensation and excess workers' compensation coverage. An insurer may use endorsements that have not been approved by the director for workers' compensation and excess workers' compensation policies if the endorsements only amend policy provisions pertaining to the calculation or remission of premiums. An insurer may not use endorsements that have not been approved if the endorsements amend coverage or alter provisions relating to the administration of claims set forth in policies filed with the director;

009.02 Medical professional liability. As required by Neb.Rev.Stat. § 44-7515 (2), only policy forms and endorsements approved by the director may be used to provide coverage for a policyholder seeking to qualify under the Nebraska Excess Medical Liability Fund;

009.03 Automobile insurance. Insurers may not use automobile insurance policy forms that provide coverage limits less than those required by Nebraska law; and

009.04 Policy forms may not violate laws. Insurers may not use policy forms that violate any law of this state.

010. Statistical reporting. Credits and debits applied pursuant to this chapter shall be reported in the same manner as credits and debits allowed by Neb.Rev.Stat. §44-7509.

011. Continued use of an unapproved policy form for a commercial policyholder that no longer qualifies as a Class RFS or Class RF exempt commercial policyholder. A policyholder may continue to purchase coverage using an unapproved policy form, even though the policyholder no longer qualifies as a Class RFS or Class RF exempt commercial policyholder, if:

- (a) Such policy form was originally agreed to during a period of time for which the policyholder could purchase coverage using policy forms which had not been approved; and
- (b) The policyholder's aggregate commercial property and casualty insurance premiums are at least \$50,000 per year.

012. Continued use of a surplus lines carrier by a commercial policyholder that no longer qualifies as a Class RFS exempt commercial policyholder. A policyholder may continue to renew coverage from a surplus lines insurer without the need to demonstrate that it is unable to obtain that coverage from a licensed insurer, even though the policyholder no longer qualifies as a Class RFS exempt commercial policyholder, if:

- (a) Such coverage was originally purchased from the surplus lines insurer during a period of time for which the policyholder could purchase coverage from a surplus lines insurer without the need to demonstrate that it is unable to obtain insurance from a licensed insurer; and
- (b) The policyholder's aggregate commercial property and casualty insurance premiums are at least \$100,000 per year.

013. Policyholder notification of policy forms that have not been approved by the director. Insurers shall inform exempt commercial policyholders prior to the inception of coverage of those policy forms applying to them that have not been approved by the director.

014. Responsibility to determine exempt commercial policyholder status. The insurer shall obtain a written statement from the policyholder regarding the information necessary to determine the policyholder's status as an exempt commercial policyholder if such status depends on information not already contained in the insurer's files. An insurer is not required to make further inquiry of the policyholder's status unless the information available to the insurer makes it unlikely that the policyholder's representations are accurate.
015. Documentation to be maintained by the insurer. An insurer shall retain documentation supporting an exemption for the time set forth in Neb.Rev.Stat. § 44-5905(2)(b)(i)(B) if the insurer uses rates or policy forms that have not been filed with or approved by the director or places coverage with a surplus lines insurer without demonstrating inability to obtain insurance from an admitted insurer.
016. Severability. If any section or portion of a section of this chapter, or the applicability thereof to any person or circumstance, is held invalid by a court, the remainder of this chapter, or the applicability of such provision to other persons, shall not be affected thereby.
017. Effective date. This chapter shall apply to all property and liability insurance subject to the Property and Casualty Insurance Rate and Form Act with an effective date on or after January 1, 2001.

### Applicability of ECP “Deregulation” By Line or Type of Insurance

Line or type of reinsurance	Rate regulation for qualifying ECP’s	Form regulation for qualifying ECP’s	Surplus Lines access for qualifying ECP’s
Aircraft (except workers’ compensation)	NRA	D	D
Commercial auto liability	D	NR <sup>1</sup>	NA <sup>2</sup>
Commercial lines insurance not otherwise shown on this table	D	D	D
Crop insurance	D	D	D
Excess WC for self-insured employers	D	R <sup>3</sup>	NA
Farm and ranch insurance	D	D	D
Financial guaranty (except loss of value for motor vehicles)	NRA	NRA	D
Medical professional liability	D	R <sup>4</sup>	NA <sup>5</sup>
Ocean marine	NRA	NRA	D
Personal lines	R	R	R
Reinsurance	NRA	NRA	NRA
Surety	NRA	NRA	D
Warranties and service contracts	NRA	NRA (except auto)	D (except auto)
Workers’ compensation, including coverage written with deductibles but <u>not</u> including excess WC written for self-insureds	D	R <sup>3</sup>	R

**D** = “Deregulated”

**R** = Regulated (that is, “deregulation” does not apply)

**NRA** = Not Regulated, Anyway (that is, for either ECP’s or non-ECP’s)

**NA** = Not Allowed

- 1 Policy forms are negotiable, but may not be written for liability limits less than required by financial responsibility laws.
- 2 Surplus lines auto liability coverage is not allowed for primary policies, but is allowed for excess policies.
- 3 Approved policy forms must be used, but provisions relating to the payment of premium may be changed with unfiled endorsements.
- 4 Policy forms used for insurance to establish qualification for the Nebraska Medical Professional Liability Excess Fund must be approved; this requirement does not apply to other medical professional liability coverage.
- 5 The Nebraska Medical Professional Liability Excess Fund will not accept policies from surplus lines carriers for qualification; this requirement does not apply to other medical professional liability coverage.

## Chapter 74

### WITHDRAWAL OF SUBJECTIVE RATING PLANS AND RATING CRITERIA

001. Purpose. The passage of LB 1119 by the 1999-2000 Nebraska Legislature enacted the Property and Casualty Insurance Rate and Form Act, which becomes operative on January 1, 2001. This Act replaces an earlier law with the same title. Section 12 of LB 1119, passed in the 2000 session of the Nebraska Legislature and codified at Neb.Rev.Stat. § 44-7512, requires that the director adopt rules to disapprove several types of rate filings effective January 1, 2001. The purpose of this Chapter is to achieve these necessary disapprovals and changes with an absolute minimum of administrative action.
002. Authority. This Chapter is promulgated under the authority vested in the Director under Neb.Rev.Stat. § 44-101.01 and Neb.Rev.Stat. § 44-7512.
003. Applicability and Scope. This Chapter applies to all property and liability insurance policies subject to the Property and Casualty Insurance Rate and Form Act delivered or issued for delivery in this state with an effective date on or after January 1, 2001.
004. Definitions.
- 004.01 The definitions provided in Neb.Rev.Stat. § 44-7504 apply for purposes of this Chapter.
- 004.02 “Intra-insurer eligibility rules” mean those rules and eligibility criteria that determine which rating program within a single insurance company is used to price an insured. It does not include any internal rules, guidelines or eligibility criteria that groups of insurers may use to determine which insurer in a group will provide coverage for specific policyholders.
- 004.03 “Objective” means based on observable phenomena and uninfluenced by personal opinion. As applied to insurance rating, this means that the same rating plan or rule will always produce the same value for the same risk regardless of competitive considerations or the insurer or the underwriter that is applying it.
- 004.04 “Subjective” means not objective. Absent filed definitional statements of objective criteria, “subjective” criteria include, but are not limited to, references to “preferred,” “standard,” and “substandard.” The development of credits or debits arising from the criteria contained in common schedule rating or “individual risk premium modification” (IRPM) plans is subjective.
005. Disapproval of Subjective Rating Plans, Subjective Rating Criteria and Subjective Intra-Insurer Eligibility Rules. For application to policies that are written or renewed with effective dates of January 1, 2001 or later, insurers’ subjective rating plans, subjective rating criteria and subjective intra-insurer eligibility rules are hereby disapproved. This

disapproval extends to all forms of individual rating plan recognition of agency commission differences.

006. Experience Rating Plans. Any previously optional experience rating plans on file for insurers are no longer optional and must be applied for all insureds for which the necessary loss experience is available and which meet the plans' filed minimum size and any other objective eligibility requirements.

007. Severability. If any section or portion of a section of this Chapter, or the applicability thereof to any person or circumstance, is held invalid by a court, the remainder of this Chapter, or the applicability of such provision to other persons, shall not be affected thereby.

008. Effective Date. This Chapter becomes effective on January 1, 2001.

## Chapter 75

### APPLICABILITY OF FORM APPROVAL PROVISIONS TO MULTI-STATE PROPERTY AND CASUALTY POLICYHOLDERS

#### 001. Purpose.

The purpose of this chapter is to implement the provisions of section 14 of LB 1119, passed in the 2000 session of the Nebraska Legislature and codified at Neb.Rev.Stat. § 44-7514 that relieve commercial policyholders primarily located in another state from the applicability of form filing requirements in Nebraska.

#### 002. Authority.

This chapter is promulgated under the authority vested in the Director under Neb.Rev.Stat. §44-101.01 and Neb.Rev.Stat. § 44-7514.

#### 003. Applicability and Scope.

This chapter applies to qualifying multistate commercial policyholders for all commercial property and liability insurance subject to the Property and Casualty Insurance Rate and Form Act.

#### 004. Definitions.

004.01 The definitions provided in Neb.Rev.Stat. § 44-7504 apply for purposes of this chapter.

004.02 Qualifying multistate commercial policyholder means an entity that meets all of the following qualifications:

- (a) The policyholder is commercial in nature.
- (b) If the policyholder is comprised of multiple corporations or other entities, there is common or majority ownership of each of the members by the same parent entity. Qualifying multistate commercial policyholder does not include franchise arrangements or other groups where individual members of the group are under different ownership.
- (c) The office with the largest number of the officers and senior management of the policyholder is located outside of Nebraska. If this criteria is not meaningful or is ambiguous for a policyholder, then the total premiums for lines of insurance subject to the Property and Casualty Insurance Rate and Form Act that are attributable to another jurisdiction must exceed those premiums attributable to Nebraska.

005. Usage of Unapproved Policy Forms.

Insurers may use policy forms for qualifying multistate commercial policyholders that have not received approval pursuant to the Property and Casualty Insurance Rate and Form Act.

006. Policy Forms; Conflicts Determined in Accordance with Nebraska Statute, when.

Policy forms for qualifying multistate commercial policyholders may include language that conflicts with Neb.Rev.Stat. §§ 44-357, 44-358, and 44-501.02. If a conflict results between a policy form and the requirements of any of these sections, then these sections shall apply.

007. Policy Forms; Conflicts Determined in Accordance with the Policy Form, when.

Policy forms for qualifying multistate commercial policyholders may include language that conflicts with Neb.Rev.Stat. §§ 44-349, 44-350, 44-501, 44-514 to 44-518, 44-520 to 44-523, and 44-6408 and the provision of § 44-601 that prohibits policies with a term longer than five years. If a conflict results between a policy form and the requirements of any of these sections, then the language in the policy form shall apply to the extent that it is inconsistent with such sections.

008. Policy Forms; Violations of Nebraska Law Prohibited.

Except as set forth in sections 005, 006 and 007 of this chapter, no insurer shall use a policy form exempted from policy form approval requirements by this chapter that violates any law of this state.

009. Severability.

If any section or portion of a section of this chapter, or the applicability thereof to any person or circumstance, is held invalid by a court, the remainder of this chapter, or the applicability of such provision to other persons, shall not be affected thereby.

010. Effective Date.

This chapter shall apply to all commercial insurance policies subject to the Property and Casualty Insurance Rate and Form Act with an effective date on or after January 1, 2001.

**Applicability of the Rate and Form Act to non-ECP Insureds (with an exception for advisory organizations\*)**

Line or type of reinsurance	Forms			Rates		
	Prior Approval	File and Use	Not Subject to Act	Prior Approval	File and Use	Not Subject to Act
Aircraft (except workers' compensation)		x				x
Commercial lines insurance not otherwise shown on this table		x			x	
Crop insurance		x			x	
Property, glass and marine written by domestic assessment associations		x				x
Farm and ranch insurance		x			x	
Financial guaranty (except loss of value for motor vehicles)			x			x
Medical professional liability	x			x		
Ocean marine			x			x
Personal lines		x			x	
Reinsurance			x			x
Surety			*			*
Warranties and service contracts			***			x
Workers' compensation generally	x				x	
Large deductible workers' compensation	x				**	
Excess WC for self-insured employers	x				**	

\* All forms and prospective loss costs developed by advisory organizations are subject to prior approval.

\*\* Large deductible and excess WC are subject to the file and use law, but they are written with such high retentions and for such large insureds that they are accorded guide rating treatment. Practically speaking, all approved self-insureds would easily qualify as rate-deregulated ECPs, as would nearly all large deductible workers' compensation policyholders.

\*\*\* Auto warranty forms are subject to filing under sections 44-3520 through 44-3526.

Please note that prior approval applies to both forms and rates for insurance that covers risks of a personal nature when covered by policies written for business entities, if the costs for the insurance are charged to individuals. Such forms and rates are not subject to ECP treatment. But this does not apply when the coverage is provided by the business to individual consumers without a separate charge.



## Form Deregulation for Multi-State Policyholders

It is easy to become confused with regard to the extent and the applicability of form deregulation for multi-state policyholders:

- Chapter 73 (the ECP rule) provides form deregulation for a policyholder with at least \$50,000 in total premium if the Nebraska premium for that policyholder is less than the premium generated by that policyholder in some other state that does not regulate rates and forms (except for WC forms, which is a common exception to forms deregulation).
- Chapter 75 (the multi-state rule) provides form deregulation for a multi-state policyholder of any size based (usually) on where the policyholder has its home office. Chapter 75's deregulation is independent of the regulation of forms or the lack thereof in the policyholder's "home state."

Although both chapters have restrictions on the amount of form deregulation that is provided, the form deregulation under Chapter 75 (the multi-state rule) is broader when it applies:

- Unlike Chapter 73, Chapter 75 does not require any notice be given to a policyholder when a form is used that has not been approved by the Nebraska Department of Insurance.
- Chapter 75 allows policy forms to conflict with specified Nebraska laws, while Chapter 73 requires that policy forms comply with all Nebraska laws.

This may lead one to ask regarding the relevance of form deregulation for multi-state policyholders in the ECP rule. While limited, it is relevant because a policyholder considered by Chapter 75 to be based in Nebraska may nevertheless generate more premium in states other than Nebraska and thus be able to pick up a degree of forms "deregulation" from the ECP rule that would not otherwise be available to it through Chapter 75 (which is based on the location of the policyholder's home office).

In general, the multi-state provisions of the ECP rule are much more relevant with regard to rate deregulation for risks primarily located in another state, as Chapter 75 (the multi-state rule) does not address rates at all. With regard to form "deregulation" for risks primarily located in another state, however, Chapter 75 – and not the ECP rule – provides broader form deregulation. There is no conflict, however, as the forms-related provisions of Chapter 73 (the ECP rule) do not apply to multi-state policyholders eligible for the broader degree of deregulation provided by Chapter 75.

Complicated? If it was easy, they wouldn't pay us so much to figure it out!

**44-7501 Act, how cited.**

Sections 44-7501 to 44-7535 shall be known and may be cited as the Property and Casualty Insurance Rate and Form Act.

**44-7502 Purposes of act.**

The purposes of the Property and Casualty Insurance Rate and Form Act are:

- (1) To prohibit price-fixing agreements and other anticompetitive behavior by insurers;
- (2) To protect policyholders and the public against excessive rates and the adverse effects of inadequate or unfairly discriminatory rates;
- (3) To regulate insurance contracts so they:
  - (a) Are not unjust, unfair, ambiguous, inconsistent, inequitable, misleading, deceptive, or contrary to public policy;
  - (b) are not written so as to encourage the misrepresentation of coverage;
  - (c) reasonably provide the general coverage for policies of that type;
  - (d) comply with the provisions and the intent of the laws of this state; and
  - (e) do not provide coverage contrary to the public interest;
- (4) To promote rates that reflect the benefits of competition;
- (5) To provide appropriate data reporting systems;
- (6) To provide regulatory oversight in the absence of competition;
- (7) To authorize essential cooperative action among insurers in the development of policy forms, prospective loss costs, and other information and to regulate such activity to prevent practices that tend to substantially lessen competition or create a monopoly; and
- (8) To promote the dissemination of price and other information to enable consumers to purchase insurance suitable for their needs and to foster competitive insurance markets.

**44-7503 Competition and uniformity; construction of act.**

Nothing in the Property and Casualty Insurance Rate and Form Act shall prohibit or discourage reasonable competition or prohibit or discourage uniformity in policy forms, rating systems, or underwriting practices except to the extent necessary to accomplish the purposes of the act. The act shall be liberally interpreted to carry into effect the purposes of the act.

**44-7504 Terms, defined.**

For purposes of the Property and Casualty Insurance Rate and Form Act:

- (1) Advisory organization means any entity, including its affiliates or subsidiaries, which (a) has majority ownership or control by two or more insurers and assists two or more insurers in activities related to ratemaking, the promulgation of policy forms, or related matters or (b) makes the same prospective loss cost or policy form filings on behalf of or to be available for two or more insurers. For purposes of this subdivision, a group of insurers under common ownership or control shall be considered a single insurer.

Advisory organization does not include joint reinsurance pools, joint underwriting pools, or insurers engaged in joint underwriting;

- (2) Classification means the process of grouping insureds with similar loss or expense characteristics so that differences in losses and expenses may be recognized;
- (3) Director means the Director of Insurance;
- (4) Exempt commercial policyholder means an entity to which specific aspects of rate or policy form regulation do not apply or have been relaxed in accordance with rules and regulations adopted and promulgated pursuant to section 44-7515;
- (5) Expense means that portion of a rate attributable to acquisition, field supervision, collection expense, general expense, taxes, licenses, and fees. Expense does not include loss adjustment expense;
- (6) Experience rating plan means a rating formula and related procedures that use past loss experience of an individual policyholder to forecast future losses by measuring the policyholder's loss experience against the expected losses for policyholders in that classification to produce a prospective premium credit, debit, or unity modification;
- (7) Joint reinsurance pool means an ongoing voluntary arrangement pursuant to which two or more insurers participate in the reinsurance of risks written by one or more member insurers and reinsured by one or more other member insurers. For purposes of this subdivision, a group of insurers under common ownership or control shall be considered a single insurer. A joint reinsurance pool may operate through an association, syndicate, or other arrangement;
- (8) Joint underwriting means a voluntary arrangement established on an individual risk basis by which two or more insurers jointly contract to provide coverage for an insured. For purposes of this subdivision, a group of insurers under common ownership or control shall be considered a single insurer. Joint underwriting does not include any arrangement by which the participants are reinsuring the direct obligation of another risk-assuming entity;
- (9) Joint underwriting pool means an ongoing voluntary arrangement pursuant to which two or more insurers participate in the sharing of risks written as their direct obligations according to a predetermined basis and the insurance remains the direct obligation of the pool participants. For purposes of this subdivision, a group of insurers under common ownership or control shall be considered a single insurer. A joint underwriting pool may operate through an association, syndicate, or other arrangement;
- (10) Loss adjustment expense means the expense incurred by an insurer in the course of settling claims;
- (11) Policy form means all policies, certificates, or other contracts providing insurance coverage. Policy form includes bonds and includes riders, endorsements, or other amendments to the policy form;
- (12) Premium means the cost of insurance to the policyholder after all audit adjustments have been made and any dividends payable have been subtracted;
- (13) Prospective loss cost means that portion of a rate intended to provide for expected losses and loss adjustment expenses. Prospective loss costs may provide for anticipated special

assessments. Prospective loss costs do not include provisions for profits, dividends, or expenses other than loss adjustment expenses;

- (14) Rating system means the information needed to determine the applicable rate or premium including rates, any manual or plan of rates, classifications, rating schedules, minimum premiums, policy fees, payment plans, rating plans or rules, anniversary rating date rules, and other similar information. Rating system does not include dividend rating plans or other provisions for the possible payment of dividends if such dividends are declared by the insurer's board of directors and are not guaranteed;
- (15) Special assessments means guaranty fund assessments made pursuant to section 44-2407, Workers' Compensation Trust Fund assessments made pursuant to section 48-162.02, residual market assessments made pursuant to section 44-7528 or 48-146.01, and similar assessments. Special assessments are not expenses or losses;
- (16) Statistical agent means an entity that, for the purpose of fulfilling the statistical reporting obligations of two or more insurers under the act, collects or compiles statistics from two or more insurers or provides reports developed from these statistics to the director. For purposes of this subdivision, a group of insurers under common ownership or control shall be considered a single insurer; and
- (17) Supporting information means the experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied upon by the filer, the interpretation of any other data relied upon by the filer, descriptions of methods used in developing a rating system, and any other information required by the director to be filed.

#### **44-7505 Applicability of act.**

- (1) The Property and Casualty Insurance Rate and Form Act applies to any insurer holding a certificate of authority issued by the director to transact insurance business in this state for the lines of insurance specified in subdivisions (5) through (14) and (16) through (20) of section 44-201 and to any combination of any of the foregoing on risks or operations in this state.
- (2) The act does not apply to:
  - (a) Reinsurance, except as provided in section 44-7525 for joint reinsurance pools;
  - (b) Ocean marine insurance;
  - (c) Rating systems for insurance against loss or damage to aircraft or against liability, other than workers' compensation and employers liability, arising out of the ownership, maintenance, or use of aircraft;
  - (d) Rating systems or policy forms used by insurers to provide warranties or service contracts, or rating systems or policy forms used by insurers to provide coverage for the risk assumed by businesses that provide warranties or service contracts for their customers;
  - (e) Rating systems or policy forms for financial guaranty insurance as defined in subdivision (19) of section 44-201, except that the act applies to financial guaranty coverage for loss of value for motor vehicles leased or sold on credit to private parties;

- (f) Rating systems for the lines of insurance specified in subdivisions (5), (7), and (18) of section 44-201 for insurance written by domestic assessment associations doing business under Chapter 44, article 8; and
- (g) Policy forms or rates for contracts of suretyship, except that policy forms and prospective loss costs developed or filed by advisory organizations are subject to the act.

**44-7506 Rating systems and prospective loss costs; filing required.**

- (1) All rating systems and prospective loss costs shall be filed with the director in accordance with section 44-7508, except that filings for the following shall be filed in accordance with sections 44-7510 and 44-7511:
  - (a) Filings made by advisory organizations;
  - (b) Medical professional liability insurance;
  - (c) Insurance in noncompetitive markets as determined pursuant to section 44-7507;
  - (d) Liability and physical damage coverages relating to the rental of private passenger automobiles on a nonfleet basis;
  - (e) Insurance written by joint underwriting pools or joint reinsurance pools;
  - (f) Insurance written in an assigned risk plan; and
  - (g) Insurance covering risks of a personal nature written for business entities if the costs for the insurance are charged to individuals. This does not include coverage provided without a separate charge by business entities for their customers.
- (2) (a) If the director, after notice and hearing in accordance with the Administrative Procedure Act, finds that an insurer has made filings pursuant to section 44-7508 that have failed to meet the filing standards contained in that section with such frequency as to indicate a general business practice that disregards the requirements of that section, the director shall order that the insurer's filings be made subject to the requirements of sections 44-7510 and 44-7511.
  - (b) Upon application by an insurer affected by an order issued pursuant to subdivision (2)(a) of this section, demonstrating that its filings made subsequent to the order have been in compliance with section 44-7508 without the need for the director to request that the original filings be amended, the director shall vacate such order. The director shall consider any such application within thirty days after its receipt for any order that has been in effect for more than nine months since its inception or since it was last reviewed by the director pursuant to an application by the insurer.
  - (c) For insurers whose rating system filings that would otherwise be subject to this section have been made subject to the prior approval requirements of section 44-7511 through the application of this subsection, the percentage rating flexibilities provided in section 44-7509 shall apply to such rating system filings made by such insurers once the rating system filing has been approved pursuant to section 44-7511.

**44-7507 Monitoring competition; determining competitive markets; hearing.**

- (1) The director shall monitor competition and the availability of insurance in commercial insurance markets. Such monitoring may include requests for information from insurers regarding the lines, types, and classes of insurance that the insurer is seeking and able to write. When requested by an insurer with its response, the director shall keep such responses confidential except as they may be compiled in summaries.
- (2) If the director finds that a commercial insurance coverage is contributing to problems in the insurance marketplace due to excessive rates or lack of availability, the director shall report this finding to the Legislature. Such report may be a separate report or a supplement to the annual report required by section 44-113.
- (3) A competitive market is presumed to exist unless the director, after notice and hearing in accordance with the Administrative Procedure Act, determines by order that a degree of competition sufficient to warrant reliance upon competition as a regulator of rating systems, policy forms, or both does not exist in the market. In determining whether a sufficient degree of competition exists, the director may consider:
  - (a) Relevant tests of workable competition pertaining to market structure, market performance, and market conduct;
  - (b) The practical opportunities available to consumers in the market to acquire pricing and other consumer information and to compare and obtain insurance from competing insurers;
  - (c) Whether long-term and short-term profitability provides evidence of excessive rates;
  - (d) Whether rating systems filed under section 44-7508 would frequently require amendment or disapproval if filed under sections 44-7510 and 44-7511;
  - (e) Whether additional competition would appear likely to significantly lower rates or improve the policy forms offered to insureds;
  - (f) Whether rates would be lowered or policy forms would be improved by the imposition of a system of prior approval regulation;
  - (g) Whether policy forms filed under section 44-7508.02 would frequently require amendment or disapproval if filed under section 44-7513; and
  - (h) Any other relevant factors.
- (4) If a market for a particular type of insurance is found to lack sufficient competition to warrant reliance upon competition as a regulator of rating systems or policy forms, the director shall identify factors that appear to be the cause and the extent to which remediation can be achieved on a short-term or long-term basis. To the extent that significant remediation can be achieved consistent with the other goals of the Property and Casualty Insurance Rate and Form Act, the director shall take such action as may be within the director's authority to accomplish such remediation or to promote the accomplishment of such remediation.
- (5) If the director finds pursuant to a hearing held in accordance with subsection (3) of this section that the lack of sufficient competition warrants the application of sections 44-7510 and 44-7511 to the rates charged for a type of insurance, an order shall be issued pursuant

to this section that applies sections 44-7510 and 44-7511 to the type of insurance. If the director finds pursuant to a hearing held in accordance with subsection (3) of this section that the lack of sufficient competition warrants the application of section 44-7513 to regulate the forms offered for a type of insurance, an order shall be issued pursuant to this section that applies section 44-7513 to the type of insurance. An order issued under this subsection shall expire no later than one year after its original issue unless the director renews the order after a hearing and a finding of a continued lack of sufficient competition. Any order that is renewed after its first year shall not exceed three years after reissue unless the director renews the order after a hearing and a finding of a continued lack of sufficient competition.

- (6) The director shall keep on file in one location all complaints from the public and insurance industry sources alleging that a competitive market does not exist. The director shall investigate each complaint to the extent necessary to determine the truth of the allegations. The director shall keep a summary of his or her findings and conclusions with the complaint.

**44-7508 Rating systems; filing requirements; hearing.**

- (1) Each insurer to which this section applies as provided in section 44-7506 shall file with the director every rating system and every modification of such rating system that it chooses to use. No insurer shall issue a contract or policy except in accordance with the filings that are in effect for such insurer as provided in the Property and Casualty Insurance Rate and Form Act, except:
  - (a) As provided in subsections (6) and (7) of this section;
  - (b) As provided by rules and regulations adopted and promulgated pursuant to section 44-7515; or
  - (c) For types of inland marine risks that have, by custom of the industry, not been written according to manual rates or rating plans. For types of inland marine risks for which the custom of the industry has not been established, the director shall consider the similarity of the new insurance to existing types of insurance and classes of risk and whether it would be reasonably practical to create and file rating systems prior to use.
- (2) Every filing shall state its effective date, which shall not be prior to the date that the director receives the filing.
- (3) Every filing shall provide an objective description of the risks and the coverages to which the rating system will apply. If the insurer has another rating system on file that applies to some or all of these same risks, the filing shall disclose this and shall objectively identify those risks to which each rating system will apply. Filings shall include a list of manual pages and other rating system elements that will be replaced when the approval of a filing will result in the replacement or alteration of previously filed rating systems. In addition, insurers shall maintain listings of manual pages and other rating system elements that have been filed with the director so that such listings can be provided upon request.
- (4) Each insurer shall file or incorporate by reference to material filed with the director all supporting information relating to a rating system. If a filing is not accompanied by such information or if additional information is required to complete review of the filing, the

director may require such insurer to furnish the information, and in that event the review period in subsection (10) of this section shall commence on the date such information is received by the director. If an insurer fails to furnish the required information within sixty days, the director may disapprove the filing based on the insurer's failure to provide the requested information. Disapproval shall be by written notice sent to the insurer ordering discontinuance of the filing within thirty days after the date of notice.

- (5) An insurer may authorize the director to accept rating system filings and prospective loss cost filings made on its behalf by an advisory organization. The insurer shall file additional information as is necessary to complete its rating systems on file with the director.
- (6) A rate or premium in excess of that provided by a filing otherwise applicable may be used on any specific risk upon the prior written consent of the insured that describes the insured's unusual or extrahazardous exposures that are not otherwise contemplated by the rates on file for that class of risk. Such signed consent shall be filed with the director no later than thirty days after the effective date of the insurance to which it applies. Insurers may not use the procedure set forth in this subsection as a regular means to gain more rate flexibility than is otherwise allowed by the Property and Casualty Insurance Rate and Form Act. The director shall monitor such rate applications to assure compliance with this subsection. The director may, after a hearing, require by order that such applications for an insurer that has demonstrated a pattern of using this rating device for risks that do not possess unusual or extrahazardous exposures or that otherwise fails to comply with this subsection shall be subject to prior approval pursuant to subdivision (6)(a) of section 44-7511. Upon application by an insurer affected by such order, demonstrating that its filings made subsequent to the order have been in compliance with this subsection, the director shall vacate such order. The director shall consider any such application within thirty days after its receipt for any order that has been in effect for more than nine months since its inception or since it was last reviewed by the director pursuant to an application by the insurer.
- (7) The director may by rules and regulations or by order suspend or modify the filing requirements of this section as to any type of insurance or class of risk for which rating systems cannot practicably be filed before they are used. In making this finding, the director shall ascertain whether a system of rating classifications and exposure bases that would equitably reflect the differences in expense requirements and expected losses between individual risks has been developed or appears reasonably capable of being developed. The director may examine insurers as is necessary to ascertain whether any rating systems affected by such rules and regulations meet the standards contained in this section and in section 44-7510.
- (8) No filing or any supporting information provided pursuant to this section shall be open to public inspection pursuant to sections 84-712 to 84-712.09 before the date on which the director completes review of the filing unless publicly disclosed in an open court, open administrative proceeding, or open meeting or disclosed by the director pursuant to statute. Correspondence specifically relating to individual risks shall be confidential and may not be made public by the director except as may be compiled in summaries of such activity.

- (9) The director shall review filings as soon as reasonably possible after they have been submitted. The director shall disapprove a filing if:
- (a) The filing proposes a rating system that would produce inadequate premiums. A premium level is inadequate if it would endanger the solvency of the insurer. A premium level that would not be expected to generate a profit on a direct basis and that would be likely to have the effect of diminishing competition is also inadequate. A premium level that does not endanger the solvency of the insurer and is not likely to have the effect of diminishing competition is not inadequate;
  - (b) The insurer has more than one rating system applicable to the line or type of insurance and the insurer fails to specify objective differences between risks to determine the risks and the coverages to which the rating system will apply;
  - (c) The filing proposes to discriminate between risks based on optional commission differences for agents;
  - (d) The filing proposes to discriminate between risks based on race, creed, national origin, or religion of the insured;
  - (e) The filing would violate the Unfair Discrimination Against Subjects of Abuse in Insurance Act; or
  - (f) The filing discriminates between risks based on subjective factors, except that an experience rating plan may use loss reserves without being considered as subjective.
- (10) Within thirty days after receipt, the director shall disapprove a filing that requires disapproval pursuant to subsection (9) of this section, except that this review period may be extended for an additional period not to exceed thirty days if the director gives written notice within the original review period to the insurer. A filing shall be deemed to meet the requirements of this section unless disapproved by the director within the review period or any extension thereof.
- (11) If, within the review period provided by subsection (10) of this section or any extension thereof, the director finds that a filing does not meet the requirements of subsection (9) of this section, a written disapproval notice shall be sent to the insurer. Such notice shall specify in what respects the filing fails to meet these requirements and order discontinuance of the filing within thirty days after the date of notice.
- (12) An insurer whose filing is disapproved may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.
- (13) If, at any time after the expiration of the review period provided by subsection (10) of this section or any extension thereof, the director finds that a rating system or modification thereof does not meet or no longer meets the requirements of subsection (9) of this section, the director shall hold a hearing in accordance with section 44-7532.
- (14) Any insured aggrieved with respect to any filing may make written application to the director for a hearing on such filing. The hearing application shall specify the grounds to be relied upon by the applicant. If the director finds that the hearing application is made in good faith, that a remedy would be available if the grounds are established, or that such

grounds otherwise justify holding a hearing, the director shall hold a hearing in accordance with section 44-7532.

- (15) If, after a hearing held pursuant to subsection (13) or (14) of this section, the director finds that a filing does not meet the requirements of subsection (9) of this section, the director shall issue an order stating in what respects such filing fails to meet the requirements and when, within a reasonable period thereafter, such rating system or aspect of a rating system shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

**44-7508.01 Policy forms and related rules of attachment; filing; contents; failure to file; effect.**

- (1) All policy forms and related rules of attachment shall be filed with the director in accordance with section 44-7508.02, except that an insurer may at its option file policy forms and related rules of attachment in accordance with section 44-7513 and filings for the following shall be filed in accordance with section 44-7513:
- (a) Filings made by advisory organizations;
  - (b) Workers' compensation and employers liability insurance;
  - (c) Excess workers' compensation and employers liability insurance;
  - (d) Medical professional liability insurance;
  - (e) Insurance in noncompetitive markets as determined pursuant to section 44-7507;
  - (f) Liability and physical damage coverages relating to the rental of private passenger automobiles on a nonfleet basis;
  - (g) Insurance written by joint underwriting pools or joint reinsurance pools;
  - (h) Insurance written in an assigned risk plan; and
  - (i) Insurance covering risks of a personal nature written for business entities if the costs for the insurance are charged to individuals. This does not include coverage provided without a separate charge by business entities for their customers.
- (2) (a) If the director, after notice and hearing in accordance with the Administrative Procedure Act, finds that an insurer has made filings pursuant to section 44-7508.02 that have failed to meet the filing standards contained in such section with such frequency as to indicate a general business practice that disregards the requirements of such section or finds that the insurer committed one or more egregious acts relating to the filing standards, the director shall order that the insurer's filings be made subject to the requirements of section 44-7513.
- (b) Upon application by an insurer affected by an order issued pursuant to subdivision (2)(a) of this section demonstrating that its filings made subsequent to the order have been in compliance with section 44-7508.02 without the need for the director to request that the original filings be amended, the director may vacate such order. The director shall consider any such application within thirty days after its receipt

for any order that has been in effect for more than nine months since its inception or since it was last reviewed by the director pursuant to an application by the insurer.

**44-7508.02 Policy forms; filing; director; powers and duties.**

- (1) For policy forms to which this section applies as provided in section 44-7508.01, each insurer shall file with the director every policy form and related attachment rule and every modification thereof which it proposes to use. For policy forms to which this section applies, no insurer shall issue a contract or policy except in accordance with the filings that are in effect for such insurer as provided in the Property and Casualty Insurance Rate and Form Act except as provided in subsection (10) or (11) of this section or as provided by rules and regulations adopted and promulgated pursuant to section 44-7514 or 44-7515.
- (2) Every filing shall state its effective date, which shall not be prior to the date that the director receives the filing.
- (3) Every policy form filing shall explain the intended use of such policy forms. Filings shall include a list of policy forms that will be replaced when the approval of a filing will result in the replacement of previously approved policy forms. In addition, insurers shall maintain listings of policy forms that have been filed so that such listings can be provided upon request.
- (4) The director shall acknowledge receipt of a policy form filing as soon as practical. A review of the filing by the director is not required to issue this acknowledgment, and acknowledgment shall not constitute an approval by the director.
- (5) The director may review a policy form filing at any time after it has been made. The director shall review a policy form filing for insurance covering risks of a personal nature, including insurance for homeowners, tenants, private passenger nonfleet automobiles, mobile homes, and other property and casualty insurance for personal, family, or household needs, within thirty days after the filing has been made. Following such review, the director shall disapprove a filing that contains provisions, exceptions, or conditions that:
  - (a) Are unjust, unfair, ambiguous, inconsistent, inequitable, misleading, deceptive, or contrary to public policy;
  - (b) are written so as to encourage the misrepresentation of coverage;
  - (c) fail to reasonably provide the general coverage for policies of that type;
  - (d) fail to comply with the provisions or the intent of the laws of this state; or
  - (e) would provide coverage contrary to the public interest.
- (6) If, within thirty days after its receipt, the director disapproves a filing that requires disapproval pursuant to subsection (5) of this section, then a written disapproval notice shall be sent to the insurer. The disapproval notice shall specify in what respects the filing fails to meet these requirements. Upon receipt of the notice of disapproval, the insurer shall cease use of the filing as soon as practical but may use the form for policies that have already been issued or when pending coverage proposals are outstanding.

- (7) If, within thirty days after its receipt, the director requests additional information to complete review of a policy form filing, the thirty-day review period allowed in subsection (6) of this section shall commence on the date such information is received by the director. If a filer fails to furnish the required information within ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.
- (8) An insurer whose filing is disapproved pursuant to subsection (6) of this section may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.
- (9) An insurer may authorize the director to accept policy form filings made on its behalf by an advisory organization.
- (10) (a) Subject to the requirements of this subsection, policy forms unique in character and designed for and used with regard to an individual risk under common ownership subject to the rate filing provisions of section 44-7508 shall be exempt from subsection (1) of this section.
  - (b) At the earliest practical opportunity, but no later than thirty days after the effective date of the policy using unfiled provisions, the insurer shall provide the prospective insured with a written listing of the policy forms that have not been filed with the director. This requirement does not apply to renewals using the same unfiled policy forms.
  - (c) A policy form that has been used in this state or elsewhere by the insurer for another risk shall not be subject to the exemption provided by this subsection, except that an insurer may use a policy form previously developed for a single risk for a second risk if the policy form is filed within sixty days after its second usage.
  - (d) The exemption provided by this subsection shall not apply to policy forms that, prior to their use by the insurer, had been filed by an advisory organization in this state or had been filed by the insurer in any jurisdiction, regardless of whether approval was received.
  - (e) The director may by rule and regulation or by order make specific restrictions relating to the exemption provided by this subsection and may require the informational filing of policy forms subject to such exemption within a reasonable time after their use. Any such informational filings specifically relating to individual risks shall be confidential and may not be made public by the director except as may be compiled in summaries of such activity.
- (11) The director may by rule and regulation suspend or modify the filing requirements of this section as to any type of insurance or class of risk for which policy forms cannot practicably be filed before they are used. The director may examine insurers as is necessary to ascertain whether any policy forms affected by such rules and regulations meet the standards contained in the Property and Casualty Insurance Rate and Form Act.
- (12) If, at any time after the expiration of the review period provided by subsection (6) of this section or any extension thereof, the director finds that a policy form, attachment rule, or modification thereof does not meet or no longer meets the requirements of subsection (5) of this section, the director shall hold a hearing in accordance with section 44-7532.

- (13) Any insured aggrieved with respect to any policy form filing subject to this section may make written application to the director for a hearing on such filing. The hearing application shall specify the grounds to be relied upon by the applicant. If the director finds that the hearing application is made in good faith, that a remedy would be available if the grounds are established, or that such grounds otherwise justify holding a hearing, the director shall hold a hearing in accordance with section 44-7532.
- (14) If, after a hearing held pursuant to subsection (12) or (13) of this section, the director finds that a filing does not meet the requirements of subsection (5) of this section, the director shall issue an order stating in what respects such filing fails to meet the requirements and when, within a reasonable period thereafter, such policy form or attachment rule shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

#### **44-7509 Premium adjustments.**

- (1) For medical professional liability insurance and for insurance subject to section 44-7508, insurers may increase or decrease premiums on an individual risk basis up to forty percent based on any factor except:
  - (a) The rate adjustment cannot be based upon the race, creed, national origin, or religion of the insured;
  - (b) The rate adjustment cannot violate the Unfair Discrimination Against Subjects of Abuse in Insurance Act; and
  - (c) The rate adjustment cannot apply to (i) insurance covering risks of a personal nature, including insurance for homeowners, tenants, private passenger nonfleet automobiles, mobile homes, and other property and casualty insurance for personal, family, or household needs or (ii) insurance covering farms and ranches, including crop insurance.
- (2) If the director finds after a hearing that (a) the utilization of this section by the insurance industry has produced a significant number of rate modifications at or near the upper limit and at the lower limit of the allowable range of modification and (b) the modifiers at and near the upper and lower limits of the allowable range of modification appear to be predominantly correlated with individual risk factors that relate to expected losses and expenses, the director may, by rules and regulations, broaden the range of plus or minus forty percent for any line or type of insurance subject to section 44-7508.
- (3) If the director finds after a hearing that modifiers at or near the upper or lower limits of the allowable range of modification are not predominantly correlated with individual risk factors that relate to expected losses and expenses, the director may, by rules and regulations, reduce the range of plus or minus forty percent for any line or type of insurance subject to section 44-7508, but such reduction shall not be to less than plus or minus twenty-five percent.

#### **44-7510 Standards for rating systems and prospective loss costs for lines subject to prior approval.**

- (1) Rating systems shall not produce premiums that are excessive. A premium level is excessive if it is likely to produce a profit that is unreasonably high for the insurance

provided or if expenses are unreasonably high in relation to services rendered. In the evaluation of a premium level, due consideration shall be given to loss experience within and outside this state; reasonably anticipated trends; investment income; special assessments, conflagration, and catastrophe hazards; a reasonable margin for profit; dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to policyholders, members, or subscribers; expense experience both countrywide and specially applicable to this state; and other relevant factors.

- (2) Rating systems shall not produce premiums that are inadequate. A premium level is inadequate only if (a) it would endanger the solvency of the insurer or (b) it would not be expected to generate a profit on a direct basis and would be likely to have the effect of diminishing competition.
- (3) (a) Rating systems shall not produce premiums that are unfairly discriminatory. Premiums are unfairly discriminatory if, after allowing for practical limitations, price differentials fail to equitably reflect differences in expense requirements or expected losses.
  - (b) Risks may be grouped by classification groupings that identify objective risk differences for the establishment of rates and prospective loss costs and for the use of rating systems.
  - (c) Rates and premiums may be modified for individual risks or groups of risks in accordance with objective standards for measuring differences among risks or groups of risks that can be demonstrated to have a probable effect upon losses or expenses. The fact that experience rating plans use loss reserves shall not be interpreted as making experience rating plans subjective.
  - (d) Notwithstanding subdivisions (3)(b) and (c) of this section, fire insurance rating plans applying to commercial risks for the sole use by advisory organizations that contain reasonable subjective rating factors, but that otherwise meet the standards contained in the Property and Casualty Insurance Rate and Form Act, shall be approved.
  - (e) A rate is not unfairly discriminatory if it is averaged broadly among persons insured under a group, franchise, or blanket policy or a mass marketed plan. Mass marketed plan means a method of selling property liability insurance wherein:
    - (i) The insurance is offered to employees of particular employers, members of particular associations or organizations, or stockholders of publicly held corporations or to persons grouped in other ways, except groupings formed principally for the purpose of obtaining such insurance; and
    - (ii) The employer or other organization has agreed to, or otherwise affiliated itself with, the sale of such insurance to its employees or other groupings of persons affiliated with it.
  - (f) An insurer may have different rate levels for otherwise similar insureds based on expense differences between coverage sold:
    - (i) Through direct sales using employees of the insurer;
    - (ii) Through direct sales by the insurer using the Internet; and
    - (iii) Through agents that are not employees of the insurer.

- (g) No risk classification or grouping may be based upon the race, creed, national origin, or religion of the insured.
- (h) No rating system may violate the Unfair Discrimination Against Subjects of Abuse in Insurance Act.
- (4) Prospective loss costs shall be as near as is practical to the expected cost of future losses, including loss adjustment expenses. Anticipated special assessments may be included with prospective loss costs.

**44-7511 Rating systems; filing requirements for lines subject to prior approval; hearings.**

- (1) Each insurer to which this section applies as provided in section 44-7506 shall file with the director every rating system and every modification of such rating system that it proposes to use. No insurer shall issue a contract or policy except in accordance with the filings that are in effect for such insurer as provided in the Property and Casualty Insurance Rate and Form Act, except:
  - (a) As provided in subsections (6) and (7) of this section;
  - (b) As provided by rules and regulations adopted and promulgated pursuant to section 44-7515; or
  - (c) For types of inland marine risks that have, by custom of the industry, not been written according to manual rates or rating plans. For types of inland marine risks for which the custom of the industry has not been established, the director shall consider the similarity of the new insurance to existing types of insurance and classes of risk and whether it would be reasonably practical to create and file rating systems prior to use.
- (2) Every filing shall state its proposed effective date, which shall not be prior to the date that the director receives the filing. Instead of a specific date, a filing may indicate that it will be effective a reasonable specified period of time after approval or that the insurer will notify the director of the effective date within ninety days after approval.
- (3) Every filing shall provide an objective description of the risks and the coverages to which the rating system will apply. If the insurer has another rating system on file or pending that applies to some or all of these same risks, the filing shall disclose this and shall objectively identify those risks to which each rating system will apply. Filings shall include a list of manual pages and other rating system elements that will be replaced when the approval of a filing will result in the replacement or alteration of previously approved rating systems. In addition, insurers shall maintain listings of manual pages and other rating system elements that have been approved by the director so that such listings can be provided upon request.
- (4) Each insurer shall file or incorporate by reference to material filed with the director all supporting information relating to a rating system. If a filing is not accompanied by such information or if additional information is required to complete review of the filing, the director may require the filer to furnish the information, and in that event the review period in subsection (10) of this section shall commence on the date such information is received by the director. If a filer fails to furnish the required information within ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.

- (5) An insurer may authorize the director to accept rating system filings and prospective loss cost filings made on its behalf by an advisory organization. The insurer shall file additional information as is necessary to complete its rating systems on file with the director.
- (6) (a) Except as otherwise provided in subdivision (6)(b) of this section for medical professional liability insurance, a rate or premium in excess of that provided by a filing otherwise applicable may be used on any specific risk upon the prior written application of the insured that describes the insured's unusual or extrahazardous exposures that are not otherwise contemplated by the rates on file for that class of risk, filed with and approved by the director.
- (b) For medical professional liability insurance, a rate or premium in excess of that provided by a filing otherwise applicable may be used for any specific medical professional upon the prior written consent of the medical professional that describes its unusual or extrahazardous exposures that are not otherwise contemplated by the rates on file for that medical professional's rate classification. Such signed consent shall be filed with the director no later than thirty days after the effective date of the insurance to which it applies. The director shall monitor such rate applications to assure compliance with this subdivision. The director may, after a hearing, require by order that such applications for an insurer that has demonstrated a pattern of using this rating device for medical professionals that do not possess unusual or extrahazardous exposures, or that otherwise fails to comply with this subdivision, shall be subject to prior approval pursuant to subdivision (6)(a) of this section. Upon application by an insurer affected by such order, demonstrating that its filings made subsequent to the order have been in compliance with this subdivision, the director shall vacate such order. The director shall consider any such application within thirty days after its receipt for any order that has been in effect for more than nine months since its inception or since it was last reviewed by the director pursuant to an application by the insurer.
- (7) The director may by rules and regulations or by order suspend or modify the filing requirements of this section as to any type of insurance or class of risk for which rating systems cannot practicably be filed before they are used. In making this finding, the director shall ascertain whether a system of rating classifications and exposure bases that would equitably reflect the differences in expense requirements and expected losses between individual risks has been developed or appears reasonably capable of being developed. The director may examine insurers as is necessary to ascertain whether any rating systems affected by such rules and regulations meet the standards contained in this section.
- (8) No filing or any supporting information provided by an insurer pursuant to this section shall be open to public inspection pursuant to sections 84-712 to 84-712.09 before the approval or disapproval of the filing unless publicly disclosed in an open court, open administrative proceeding, or open meeting or disclosed by the director pursuant to statute. Correspondence specifically relating to individual risks shall be confidential and may not be made public by the director except as may be compiled in summaries of such activity.

- (9) The director shall review filings as soon as reasonably possible after they have been made. The director shall disapprove a filing if:
- (a) The filing fails to meet the standards contained in section 44-7510;
  - (b) The insurer has more than one rating system applicable to the line or type of insurance and the insurer fails to specify objective differences between risks to determine the risks and the coverages to which the rating system will apply;
  - (c) The filing proposes to discriminate between risks based on optional commission differences for agents; or
  - (d) The filing discriminates between risks based on subjective factors, except that (i) an experience rating plan may use loss reserves without being considered as subjective and (ii) a fire insurance rating plan applying to commercial risks filed for the sole use by an advisory organization may be approved even though it contains subjective rating factors.
- (10) Within thirty days after receipt, the director shall approve a filing that meets the requirements of the act, except that this review period may be extended for an additional period not to exceed thirty days if the director gives written notice within the original review period to the insurer or advisory organization. A filing shall be deemed to meet the requirements of the act unless disapproved by the director within the review period or any extension thereof.
- (11) If, within the review period provided by subsection (10) of this section or any extension thereof, the director finds that a filing does not meet the requirements of the act, a written disapproval notice shall be sent to the insurer. Such notice shall specify in what respects the filing fails to meet these requirements and state that such filing shall not become effective.
- (12) Filings shall become effective on their proposed effective date if approved or deemed approved on or before that date. Filings approved or deemed approved after their proposed effective dates shall become effective after notification by the insurer of a revised effective date, which shall not be prior to the date that the insurer mails the notification to the director. If an insurer fails to furnish a revised effective date within a reasonable period of time not less than ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.
- (13) An insurer or advisory organization whose filing is disapproved may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.
- (14) If, at any time after approval, the director finds that a rating system or modification thereof does not meet or no longer meets the requirements of the act, the director shall hold a hearing in accordance with section 44-7532.
- (15) Any insured aggrieved with respect to any filing may make written application to the director for a hearing on such filing. The hearing application shall specify the grounds to be relied upon by the applicant. If the director finds that the hearing application is made in good faith, that a remedy would be available if the grounds are established, or that such grounds otherwise justify holding a hearing, the director shall hold a hearing in accordance with section 44-7532.

- (16) If, after a hearing initiated pursuant to subsection (14) or (15) of this section, the director finds that a filing does not meet the requirements of the act, the director shall issue an order stating in what respects such filing fails to meet the requirements and when, within a reasonable period thereafter, such rating system or aspect of a rating system shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

**44-7512 Disapproval of subjective aspects of rating systems in effect prior to January 1, 2001.**

No later than January 1, 2001, the director shall adopt and promulgate rules and regulations to disapprove subjective rating criteria effective January 1, 2001, in order to bring rating systems in compliance with the Property and Casualty Insurance Rate and Form Act. The rules and regulations shall require the refiling of rating systems for insurers and filings when refiling is unavoidable to meet the requirements of the act, but shall attempt to minimize the number of rating systems that must be refiled. The rules and regulations may allow insurers to indicate in a written statement filed with the director that the insurer will discontinue use of subjective rating criteria effective January 1, 2001.

**44-7513 Policy form filings.**

- (1) Each insurer to which this section applies as provided in section 44-7508.01 shall file with the director every policy form and related attachment rule and every modification thereof which it proposes to use. No insurer to which this section applies shall issue a contract or policy except in accordance with the filings that are in effect for such insurer as provided in the Property and Casualty Insurance Rate and Form Act except as provided in subsection (6) or (7) of this section or as provided by rules and regulations adopted and promulgated pursuant to section 44-7514 or 44-7515.
- (2) Every filing shall state its proposed effective date, which shall not be prior to the date that the director receives the filing. Instead of a specific date, a filing may indicate that it will be effective a reasonable specified period of time after approval or that the insurer will notify the director of the effective date within ninety days after approval.
- (3) Every policy form filing shall explain the intended use of such policy forms. Filings shall include a list of policy forms that will be replaced when the approval of a filing will result in the replacement of previously approved policy forms. In addition, insurers shall maintain listings of policy forms that have been filed and approved by the director so that such listings can be provided upon request.
- (4) If additional information is needed to complete review of a policy form filing, the director may require the filer to furnish the information and in that event the review period in subsection (10) of this section shall commence on the date such information is received by the director. If a filer fails to furnish the required information within ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.
- (5) An insurer may authorize the director to accept policy form filings made on its behalf by an advisory organization.

- (6) (a) Subject to the following requirements, policy forms unique in character and designed for and used with regard to an individual risk under common ownership subject to the rate filing provisions of section 44-7508 shall be exempt from the approval requirements contained in subsection (1) of this section.
- (b) At the earliest practical opportunity, but no later than thirty days after the effective date of the policy using unfiled provisions, the insurer shall provide the prospective insured with a written listing of the policy forms that have not been approved by the director and receive written acknowledgment from prospective insureds for which it ultimately provides coverage. This requirement does not apply to renewals using the same unfiled policy forms.
  - (c) A policy form that has been used in this state or elsewhere by the insurer for another risk shall not be subject to the exemption provided by this subsection, except that an insurer may use a policy form previously developed for a single risk for a second risk if the policy form is filed for approval within sixty days after its second usage.
  - (d) The exemption provided by this subsection shall not apply to excess workers' compensation or to policy forms that, prior to their use by the insurer, had been filed by an advisory organization in this state or had been filed by the insurer in any jurisdiction, regardless of whether approval was received.
  - (e) The director may by rules and regulations or by order make specific restrictions relating to the exemption provided by this subsection and may require the informational filing of policy forms subject to such exemption within a reasonable time after their use.
- (7) The director may by rules and regulations suspend or modify the filing requirements of this section as to any type of insurance or class of risk for which policy forms cannot practicably be filed before they are used. The director may examine insurers as is necessary to ascertain whether any policy forms affected by such rules and regulations meet the standards contained in the act.
- (8) No filing or any supporting information provided by an insurer pursuant to this section shall be open to public inspection pursuant to sections 84-712 to 84-712.09 before the approval or disapproval of the filing unless publicly disclosed in an open court, open administrative proceeding, or open meeting or disclosed by the director pursuant to statute. Correspondence specifically relating to individual risks shall be confidential and may not be made public by the director except as may be compiled in summaries of such activity.
- (9) The director shall review filings as soon as reasonably possible after they have been made. The director shall disapprove a filing that contains provisions, exceptions, or conditions that:
- (a) Are unjust, unfair, ambiguous, inconsistent, inequitable, misleading, deceptive, or contrary to public policy;
  - (b) are written so as to encourage the misrepresentation of coverage;
  - (c) fail to reasonably provide the general coverage for policies of that type;

- (d) fail to comply with the provisions or the intent of the laws of this state; or
  - (e) would provide coverage contrary to the public interest.
- (10) Within thirty days after receipt, the director shall approve filings that meet the requirements of the act, except that this review period may be extended for an additional period not to exceed thirty days if the director gives written notice within the original review period to the insurer or advisory organization. A filing shall be deemed to meet the requirements of the act unless disapproved by the director within the review period or any extension thereof.
  - (11) If, within the review period provided by subsection (10) of this section or any extension thereof, the director finds that a filing does not meet the requirements of the act, a written disapproval notice shall be sent to the insurer. Such notice shall specify in what respects the filing fails to meet these requirements and state that such filing shall not become effective.
  - (12) Filings shall become effective on their proposed effective date if approved or deemed approved on or before that date. Filings approved or deemed approved after their proposed effective dates shall become effective after notification by the insurer of a revised effective date, which shall not be prior to the date that the insurer mails the notification to the director. If an insurer fails to furnish a revised effective date within a reasonable period of time not less than ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.
  - (13) An insurer or advisory organization whose filing is disapproved may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.
  - (14) If, at any time after approval, the director finds that a policy form, attachment rule, or modification thereof does not meet or no longer meets the requirements of the act, the director shall hold a hearing in accordance with section 44-7532.
  - (15) Any insured aggrieved with respect to any filing may make written application to the director for a hearing on such filing. The hearing application shall specify the grounds to be relied upon by the applicant. If the director finds that the hearing application is made in good faith, that a remedy would be available if the grounds are established, or that such grounds otherwise justify holding a hearing, the director shall hold a hearing in accordance with section 44-7532.
  - (16) If, after a hearing initiated pursuant to subsection (14) or (15) of this section, the director finds that a filing does not meet the requirements of the act, the director shall issue an order stating in what respects such filing fails to meet the requirements and when, within a reasonable period thereafter, such policy form or attachment rule shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

**44-7514 Policy form approval requirements applying to multistate commercial risks; exemption.**

- (1) The director shall adopt and promulgate rules and regulations to provide that the policy form approval requirements set forth in section 44-7513 shall not apply to policies written

for individual commercial risks that are headquartered in another state or jurisdiction. To determine whether a commercial risk is headquartered in this state, such rules and regulations shall primarily consider where the largest number of the officers and senior management are physically located.

- (2) Policy forms for commercial risks exempted by the rules and regulations adopted and promulgated pursuant to subsection (1) of this section may include language that conflicts with sections 44-357, 44-358, and 44-501.02. If a conflict results between a policy form and the requirements of such sections, such sections shall apply.
- (3) Policy forms for commercial risks exempted by the rules and regulations adopted and promulgated pursuant to subsection (1) of this section may include language that conflicts with sections 44-349, 44-350, 44-501, 44-514 to 44-518, 44-520 to 44-523, and 44-6408 and the provision of section 44-601 that prohibits policies with a term longer than five years. If a conflict results between a policy form and the requirements of any of these sections, the language in the policy form shall apply to the extent that it is inconsistent with such sections.
- (4) Except as set forth in subsections (2) and (3) of this section, the rules and regulations adopted and promulgated pursuant to this section shall require that policy forms exempted from policy form approval requirements do not violate any law of this state.

**44-7515 Exemption from the requirement for insurers to use filed rates and policy forms for certain commercial policyholders.**

- (1) The director shall adopt and promulgate rules and regulations to modify or eliminate requirements for insurers to use filed rates and policy forms for commercial policyholders under common ownership identified through the application of subsection (4) of this section.
- (2) The rules and regulations adopted and promulgated pursuant to this section may establish requirements and thresholds that differ by line or type of insurance or that differ for rates and policy forms.
- (3) The rules and regulations adopted and promulgated pursuant to this section shall require insurers to inform exempt commercial policyholders at the earliest practical date, but no later than thirty days after the inception of coverage, of those policy forms applying to them that have not been approved by the director.
- (4) The director shall consider the following factors in determining those commercial policyholders to which the rules and regulations adopted and promulgated pursuant to this section shall apply:
  - (a) For modification or elimination of the applicability of filed rates, characteristics of insureds that are likely to avail themselves of regular price comparisons between competing insurers and are likely to study and understand the differences and details of pricing proposals that they receive;
  - (b) For modification or elimination of the applicability of filed rates, characteristics of insureds for which filed rates and rating plans are less likely to provide the lowest premiums otherwise consistent with the provisions of the Property and Casualty Insurance Rate and Form Act;

- (c) Modification or elimination of the applicability of filed rates for commercial insureds that are primarily located in another jurisdiction where they are subject to similar exemptions or waivers in that jurisdiction;
  - (d) For modification or elimination of the applicability of filed policy forms, characteristics of insureds that are likely to study and understand the details of their business risks and insurance coverages and exclusions;
  - (e) For modification or elimination of the applicability of filed policy forms, characteristics of insureds that are likely to require individually written policies, as contrasted to insureds that can customarily have their coverage needs met using policy forms that could also be used for other insureds;
  - (f) For both rates and policy forms, favorable or adverse experiences with the modification or elimination of regulatory requirements, especially the experience in this state; and
  - (g) Any other relevant factor.
- (5) For exempt commercial policyholders to which rating system regulation is made otherwise inapplicable, insurers shall allocate premiums between policies, exposures, and states in proportion to the expected losses and expenses for those policies, exposures, and states.
- (6) The following restrictions apply to rules and regulations adopted and promulgated pursuant to this section:
- (a) The rules and regulations may not allow any reduction of the benefits payable under workers' compensation or excess workers' compensation policies or any alteration of provisions for the handling and settlement of claims under such policies, but the rules and regulations may allow exempt commercial policyholders to negotiate workers' compensation or excess workers' compensation premiums and premium payment provisions;
  - (b) The rules and regulations may not allow any reduction of automobile insurance coverage limits to less than those required by Nebraska law, but the rules and regulations may allow exempt commercial policyholders to negotiate automobile insurance premiums and premium payment provisions;
  - (c) The rules and regulations may not allow any limitation of the coverage provisions necessary for health care providers to qualify under the Nebraska Hospital-Medical Liability Act, but the rules and regulations may allow exempt commercial policyholders to negotiate medical professional liability insurance premiums and premium payment provisions;
  - (d) The rules and regulations may not reduce the rate regulatory requirements applying to any policyholder with total premiums of less than twenty-five thousand dollars for lines of insurance subject to the Property and Casualty Insurance Rate and Form Act; and
  - (e) The rules and regulations may not reduce the form regulatory requirements applying to any policyholder with total premiums of less than fifty thousand

dollars for lines of insurance subject to the Property and Casualty Insurance Rate and Form Act.

- (7) Policy forms for commercial risks exempted by the rules and regulations adopted and promulgated pursuant to this section may include language that conflicts with section 44-501. If a conflict results between a policy form and the requirements of section 44-501, the language in the policy form shall apply to the extent that it is inconsistent with such section.

**44-7516 Use of nonadmitted insurers by exempt commercial policyholders.**

- (1) The director shall adopt and promulgate rules and regulations to allow exempt commercial policyholders to be exempt from those provisions of sections 44-5510 and 44-5511 that require, as a condition for the purchase of insurance from a nonadmitted insurer, that applicants demonstrate an inability to obtain insurance from a licensed insurer. Such exemption shall not apply to workers' compensation insurance, excess workers' compensation insurance, or automobile liability insurance, except that such exemption may apply to automobile liability insurance purchased as excess insurance over a policy that provides limits that are at least equal to the minimum limits of liability required by section 60-534.
- (2) The rules and regulations adopted and promulgated pursuant to this section may establish requirements and thresholds that differ by line or type of insurance or that differ from the requirements and thresholds for exemption from rate and policy form requirements adopted and promulgated pursuant to section 44-7515.
- (3) In addition to the factors specified in section 44-7515, the director shall consider the following in making a determination of the requirements and thresholds that will apply:
  - (a) The relationship of deductibles, self-insured retentions, and limits of liability purchased by insureds versus the protection provided by the Nebraska Property and Liability Insurance Guaranty Association;
  - (b) The characteristics of insureds likely to be able to evaluate the ability of a nonadmitted insurer to meet its policy obligations; and
  - (c) The characteristics of insureds likely to be able to resolve policy and claims disputes that they may have with a nonadmitted insurer.
- (4) The rules and regulations may not exempt any policyholder with total premiums of less than one hundred thousand dollars for lines of insurance subject to the Property and Casualty Insurance Rate and Form Act.

**44-7516.01 Private passenger automobile liability policy; disclosure; requirements.**

- (1) On and after July 1, 2002, no private passenger automobile liability policy shall be delivered, issued for delivery, or renewed with respect to any motor vehicle licensed in this state unless accompanied by a disclosure showing the location used to determine the rate charged to the named insured and if any credit-based rating was used to determine the rate charged.
- (2) For an insurer determined by the director to be an insurer with a substantial market share of the private passenger automobile insurance premium written in this state:

- (a) The private passenger automobile liability insurance rating territories for motor vehicles located in a city of the metropolitan class that are contained in the insurer's qualifying rate filing made on or after January 1, 2002, shall be deemed to expire three years after their effective date unless they are refiled;
- (b) Unless the insurer has made a qualifying rate filing with an effective date on or after January 1, 2002, as provided in subdivision (2)(a) of this section, all filings made by the insurer of private passenger automobile insurance that justify the rating relativities of a rating territory for motor vehicles located in a city of the metropolitan class shall expire July 1, 2003;
- (c) If necessary for the director to complete his or her study of a rating system filing that is proposed as a qualifying rate filing, the director shall extend the three-year period if the insurer has made a proposed qualifying rate filing prior to the end of the three-year period with a requested effective date no later than three years after the effective date of its last qualifying rate filing;
- (d) A filing made by an advisory organization on behalf of an insurer shall be deemed to be a filing by the insurer for purposes of the expiration requirement of this subsection; and
- (e) For purposes of this subsection:
  - (i) Insurer with a substantial market share of the private passenger automobile insurance premium written in this state means:
    - (A) An insurer that is one of the ten insurers writing the largest amount of private passenger automobile insurance premium in this state; or
    - (B) An insurer that meets any other standard prescribed by rule and regulation adopted and promulgated by the director; and
  - (ii) Qualifying rate filing means an approved rating system filing that justifies the rating relativities of the private passenger automobile liability insurance rating territories for motor vehicles located in a city of the metropolitan class made on or after January 1, 2002.

#### **44-7517 Information to be furnished insureds; hearing; appeal.**

Within a reasonable time after receiving a written request and after receiving payment of such reasonable charge as it may require, every insurer and advisory organization shall furnish all pertinent information to any insured affected by a rate, premium, or prospective loss cost made by the insurer or advisory organization. Upon written request, every insurer and advisory organization shall provide within this state reasonable means by which the insured aggrieved by the application of the advisory organization's or insurer's rating system may be heard, in person or by an authorized representative, to review the manner in which such rating system has been applied in connection with the insurance afforded the insured. If the insurer or advisory organization fails to act upon such request within thirty days after it is made, the applicant may proceed in the same manner as if the application had been rejected. An insured affected by the action of the insurer or advisory organization on such request may appeal to the director within thirty days after written notice of such action. The director, after a hearing held in accordance

with section 44-7532, may affirm the action of the insurer or advisory organization or order remedial action to be undertaken by the insurer or advisory organization.

**44-7518 Advisory organizations and statistical agents; certificate of authority required; application; director; powers.**

- (1) No advisory organization or statistical agent shall provide any service relating to insurance subject to the Property and Casualty Insurance Rate and Form Act, and no insurer shall use the services of such advisory organization or statistical agent for such purposes, unless the advisory organization or statistical agent has been issued a certificate of authority by the director. Such certificate of authority shall expire on April 30 each year and shall be renewed annually if the advisory organization or statistical agent has continued to comply with the laws of this state and the rules and regulations of the director.
- (2) No advisory organization or statistical agent shall refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.
- (3) An advisory organization or statistical agent applying to the director for a certificate of authority shall include with its application:
  - (a) A copy of its constitution, charter, articles of incorporation, organization, agreement, or association, bylaws, plan of operation, and other rules or regulations governing the conduct of its business;
  - (b) The names of insurers that own or have control over the applicant, and a description of their ownership or control;
  - (c) The name and address of a resident of this state upon whom notices, process, or orders of the director may be served;
  - (d) Information showing its qualifications for acting in the capacity for which it seeks a certificate of authority;
  - (e) Biographical information on its officers; and
  - (f) Any other relevant information and documents that the director may require.
- (4) Every applicant for a certificate of authority shall notify the director of all material changes in the information or documents on which its application was based. Any amendment to a document filed under this section shall be filed at least thirty days before it becomes effective.
- (5) The director shall issue a certificate of authority stating the authorized activity of the applicant for those applicants that meet all requirements of the law and are competent, trustworthy, and qualified to provide the services proposed. The authorized activity of an advisory organization or statistical agent may be limited to specified lines or types of insurance.
- (6) The director may at any time, after a hearing in accordance with section 44-7532, suspend or revoke the certificate of authority of an advisory organization or statistical agent that does not comply with the requirements of the act.

- (7) An applicant requesting a certificate of authority to operate both as an advisory organization and as a statistical agent may be so authorized under a single certificate.

**44-7519 Insurers, advisory organizations, and statistical agents; prohibited acts.**

- (1) No insurer, advisory organization, or statistical agent shall attempt to monopolize or combine or conspire with any other person to monopolize an insurance market or to engage in a boycott, on a concerted basis, of an insurance market.
- (2) No insurer shall agree with any other insurer or with any advisory organization or statistical agent to require adherence to or to require use of any aspect of any rating system, form, prospective loss cost, dividend payment practice, underwriting rule or practice, survey, inspection, or similar material except as required by section 44-7524 or as is necessary to develop statistical plans. This subsection shall not apply to agreements between insurers under the same ownership.
- (3) No advisory organization or statistical agent shall agree with any insurer or with another advisory organization or statistical agent to require adherence to or to require use of any aspect of any rating system, form, prospective loss cost, dividend payment practice, underwriting rule or practice, survey, inspection, or similar material except as required by section 44-7524 or as is necessary to develop statistical plans.
- (4) The fact that two or more insurers, whether or not members or subscribers of an advisory organization, consistently or intermittently use the same rates, rating systems, forms, prospective loss costs, underwriting rules or practices, surveys, inspections, or similar materials shall not be sufficient basis to establish a violation of this section.
- (5) No insurer, advisory organization, or statistical agent shall make any arrangement with any other insurer, advisory organization, statistical agent, or other person which has the purpose or effect of unreasonably restraining trade or of substantially lessening competition in the business of insurance.

**44-7520 Advisory organizations and statistical agents; prohibited activities.**

Except as permitted in sections 44-7521 and 44-7522, no advisory organization or statistical agent shall compile, file, or distribute recommendations relating to rating systems that include profits, dividends, or expenses other than loss adjustment expenses.

**44-7521 Statistical agents; authorized activities.**

A statistical agent may, for the lines of insurance for which it has been licensed:

- (1) Develop statistical plans including territorial and class definitions;
- (2) Collect and distribute statistical data from insurers or any other source;
- (3) Collect, compile, and publish past and current rates charged by individual insurers if such information is also made available to the general public at no more than a reasonable cost;
- (4) Collect and compile exposure and loss experience for the purpose of individual risk experience ratings;
- (5) Undertake educational activities relating to the collection, compilation, or interpretation of insurance-related data;
- (6) Distribute any other information that is filed with the director; and

- (7) Furnish any other services, as approved or directed by the director, related to those enumerated in this section.

**44-7522 Advisory organizations; authorized activities.**

An advisory organization may, for the lines of insurance for which it has been licensed:

- (1) Engage in those activities enumerated in section 44-7521;
- (2) Prepare, file, and distribute prospective loss costs;
- (3) Prepare, file, and distribute manuals of rating rules, rating schedules, experience rating plans and other supplementary rating information that do not include final rates, expense provisions, profit provisions, or minimum premiums;
- (4) Prepare and distribute experience rating plan modifiers for individual policyholders;
- (5) Prepare, file, and distribute factors, calculations, or formulas pertaining to classification, territory, and other variables;
- (6) Prepare, file, and distribute increased limits factors, which may include an incremental profit load, also called a risk load;
- (7) Conduct research and inspections in order to prepare classifications of public fire defenses or to evaluate the effectiveness of building codes and their enforcement;
- (8) Conduct inspections to determine rating classifications for individual insureds;
- (9) Consult with public officials regarding public fire protection as it would affect members, subscribers, and others;
- (10) Conduct research in order to discover, identify, and classify information relating to causes or prevention of losses;
- (11) Prepare, file, and distribute policy forms and gather information from members, subscribers, and others relative to the application and interpretation of the policy forms;
- (12) Conduct research and inspections for the purpose of providing risk information relating to individual structures;
- (13) If instructed by the director, file rates instead of prospective loss costs for assigned risk or other residual market mechanisms;
- (14) Conduct research to determine the impact of statutory changes upon prospective loss costs;
- (15) Undertake educational activities on the use of policy forms, analysis of losses, loss trends, loss reserves, expenses, and other policy form and ratemaking topics;
- (16) For workers' compensation insurance, establish a committee that may include insurance company representatives to review the application of the classification system for individual insureds and to suggest modifications to the classification system;
- (17) Distribute any other information that is filed with the director; and
- (18) Furnish any other services approved or directed by the director related to the services enumerated in this section.

**44-7523 Advisory organizations; general filing requirements applicable.**

Filings by an advisory organization of prospective loss costs, rating systems or policy forms and related attachment rules shall be subject to the provisions of the Property and Casualty Insurance Rate and Form Act applicable to filings generally. Rating system filings by an advisory organization shall be subject to the provisions of sections 44-7510 and 44-7511.

**44-7524 Workers' compensation; uniform classification system required; premiums; how calculated.**

- (1) Every workers' compensation insurer shall adhere to a uniform classification system and shall report its experience in accordance with statistical plans and other reporting requirements to ensure that data is combined for all insurers for the development of prospective loss costs and the application of experience rating.
- (2) Every insurer shall utilize experience rating plan modifiers developed by an advisory organization pursuant to an experience rating plan approved by the director.
- (3) A workers' compensation insurer may develop subclassifications of the uniform classification system upon which a rate may be made. Such subclassifications and the filing shall be subject to the provisions of the Property and Casualty Insurance Rate and Form Act applicable to rating system filings generally.
- (4) The director shall disapprove subclassifications, rating plans, or other variations from manual rules filed by a workers' compensation insurer or advisory organization if the insurer or advisory organization fails to demonstrate that the data produced can be reported consistently with the uniform classification system and experience rating system and will allow for the application of experience rating.
- (5) Workers' compensation premiums shall be calculated on a basis that, as nearly as is practicable, after the effects of experience rating and other applicable rating plans have been considered, the sum of expected losses and expected expenses as a percentage of premium shall be the same for high-wage-paying and low-wage-paying employers in the same job classification.

**44-7525 Joint underwriting; joint reinsurance; requirements; director; powers.**

- (1) Every joint underwriting pool or joint reinsurance pool shall file with the director a copy of its constitution, articles of incorporation, organization, agreement, or association, bylaws, and other rules and regulations governing its activities, a listing of its members, the name and address of a resident of this state upon whom notices, process, or orders of the director may be served, and any amendments or changes thereto.
- (2) Notwithstanding section 44-7519, insurers participating in joint underwriting or in joint underwriting pools or joint reinsurance pools may, in connection with such activity, act in cooperation with each other in the development of rates, rating systems, policy forms, underwriting rules, surveys, inspections, and investigations, the furnishing of loss and expense statistics or other information, or the conducting of research.
- (3) Except as provided in this section, joint underwriting, joint underwriting pool, and joint reinsurance pool activities shall be subject to the Property and Casualty Insurance Rate and Form Act.

- (4) If, after a hearing in accordance with section 44-7532, the director finds that any activity or practice of an insurer participating in joint underwriting, a joint underwriting pool, or a joint reinsurance pool will tend to lessen competition in any market or is otherwise inconsistent with the provisions or purposes of the act, the director may issue an order requiring the discontinuance of such activity or practice.

#### **44-7526 Examinations.**

- (1) To ascertain compliance with the Property and Casualty Insurance Rate and Form Act, the director may, as often as is deemed to be expedient, make or cause to be made an examination of each advisory organization, statistical agent, joint underwriting pool, or joint reinsurance pool doing business in this state. The advisory organization, statistical agent, or pool examined shall pay the reasonable costs of any such examination. The officers, manager, agents, and employees of such advisory organization, statistical agent, or pool may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation.
- (2) In lieu of any such examination, the director may accept (a) the report of an examination made by the insurance supervisory official of another state or (b) the report of an independent certified public accountant in good standing with the American Institute of Certified Public Accountants. Every such advisory organization, statistical agent, joint underwriting pool, or joint reinsurance pool shall, within thirty days after the receipt of a final examination report of any other state, provide a copy of the report to the director. Every such advisory organization, statistical agent, joint underwriting pool, or joint reinsurance pool shall, within thirty days after the publication or public filing of a report made by an independent certified public accountant, provide a copy of the report to the director.

#### **44-7527 Statistical data; collection and exchange; rules and regulations.**

- (1) The director shall adopt and promulgate rules and regulations to assure that the experience of all insurers is provided to the director at least annually in such form and detail as is necessary to aid in effecting the purposes of the Property and Casualty Insurance Rate and Form Act. The director may designate one or more statistical agents to assist in gathering such experience and making compilations thereof. The scope of such rules and regulations may include the data which must be reported by insurers, definitions of data elements, the timing and frequency of statistical reporting by insurers, data quality standards, data edit and audit requirements, data retention requirements, reports to be generated by statistical agents to fulfill the requirements of this section, and the timing of such reports.
- (2) Should the director choose to designate more than one statistical agent to assist for a line or type of insurance, the director may adopt and promulgate rules and regulations necessary to ensure that statistical data that the director has required is combined for reports to the director.
- (3) The following provisions apply only to the disclosure of data and reports provided to the director pursuant to this section and to the disclosure of reports produced by the director from data and reports provided pursuant to this section:
  - (a) The director shall not disclose data that identifies individual insurers;

- (b) The director shall not disclose data that is likely to identify individual policyholders or claimants or when there is reason to suspect that individual open claim reserves may be identified with individual policyholders or claimants;
  - (c) The director may agree in advance to withhold data from public disclosure when confidentiality is requested by the statistical agent providing the data to the director, but only if the data include data elements that the director had not required, prior to their writing or occurrence, to be recorded by insurers; and
  - (d) All other data contained in reports made pursuant to this section shall be subject to public disclosure.
- (4) The director may adopt and promulgate rules and regulations for the interchange of data necessary for the application of rating plans.
  - (5) In order to further uniform administration of rate regulatory laws, the director and every insurer and advisory organization may exchange information and experience data with insurance supervisory officials, insurers, and advisory organizations in other states and may consult with them with respect to the application of rating systems.

**44-7528 Applicants unable to procure insurance; apportionment among insurers.**

Insurers may agree to the equitable apportionment among them of insurance to be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods. Such insurers may agree on the use of policy forms, rating systems, and reasonable modifications thereof for such insurance. Such agreements may include pooling arrangements or reinsurance. Such agreements, policy forms, rating systems, and modifications thereof shall be subject to the approval of the director.

**44-7529 False or misleading information; prohibited acts.**

No person shall willfully withhold information that will affect the forms applicable, dividends payable, or rates or premiums chargeable from the director or any statistical agent, advisory organization, or insurer. No person shall knowingly give false or misleading information that will affect the policy forms applicable, dividends payable, or rates or premiums chargeable to the director or any statistical agent, advisory organization, or insurer. A person who violates this section shall be subject to provisions of section 44-7530.

**44-7530 Violations; director; hearing; powers and duties.**

- (1) Whenever the director has reason to believe that any person has violated any provision of the Property and Casualty Insurance Rate and Form Act, the director shall hold a hearing in accordance with section 44-7532. If, after such hearing, the director determines that the person has violated any provision of the act, the director may order any one or more of the following:
  - (a) Payment of an administrative penalty of not more than one thousand dollars for every act or violation but not to exceed an aggregate penalty of ten thousand dollars in any six-month period unless the person knew or reasonably should have known of the violation of the act, in which case the penalty shall be not more than five thousand dollars for every act or violation not to exceed an aggregate penalty of fifty thousand dollars in any six-month period; and

- (b) Suspension or revocation of the person's license or certificate of authority if such person knew or reasonably should have known of the violation.
- (2) The powers, remedies, procedures, and penalties provided in the act shall be in addition to any other penalty, remedies, procedures, and penalties provided by law.

**44-7531 Hearing; request.**

Any insurer, joint underwriting pool, joint reinsurance pool, statistical agent, or advisory organization aggrieved by any order or decision of the director made without a hearing may, within thirty days after notice of the order, make written request to the director for a hearing thereon in accordance with section 44-7532. Pending such hearing and decision, the director may suspend the effective date of his or her action.

**44-7532 Hearing; procedure.**

If a hearing is held at the request of a party other than the director, unless mutually agreed upon by the director and all interested parties, notice of hearing shall be provided within thirty days after the director's receipt of a written request for a hearing. Notice of hearing shall be given to all interested parties and shall state the time, place, and purpose of the hearing. Unless mutually agreed upon by the director and all interested parties, the hearing shall be held not less than ten days after notice is served. Unless mutually agreed upon by the director and all interested parties or unless the hearing is being held at the request of the director, the hearing shall be held not more than thirty days after notice is served.

**44-7533 Appeals.**

Any order or decision of the director made pursuant to the Property and Casualty Insurance Rate and Form Act may be appealed by any party in interest. The appeal shall be in accordance with the Administrative Procedure Act.

**44-7534 Electronic filings and correspondence.**

The director may make reasonable arrangements and adopt and promulgate rules and regulations to allow or to facilitate the use of electronic media to make filings or to engage in correspondence required by the Property and Casualty Insurance Rate and Form Act.

**44-7535 Rules and regulations.**

The director may adopt and promulgate rules and regulations to carry out the Property and Casualty Insurance Rate and Form Act. The rules and regulations shall not be effective prior to January 1, 2001.

**These are the laws that are referenced and affected (or not affected) by Chapter 75 (dealing with Nebraska policyholders that are primarily located in another state):**

**44-349. Policies; state type of company.**

No policy or contract of insurance or renewal thereof shall be made, issued, used, or delivered by any insurer in this state unless it states on its face whether it is issued by a stock, mutual, reciprocal, assessment, or fraternal company; PROVIDED, that any insurer organized under special charter provisions may so indicate upon its policy and may add a statement of the plan under which it operates in this state.

**44-350. Insurance companies; use of name; policies; state name of company; exceptions.**

Every insurance company shall conduct its business in this state in its own name, and the policies and contracts of insurance issued by it shall be headed or entitled by such name. Two or more companies may jointly issue an underwriter's policy, upon which must appear the names of the companies guaranteeing the same, and such companies shall be jointly and severally liable thereon; PROVIDED, this limitation shall not apply to any insurance company admitted to this state and issuing an underwriter's policy prior to the passage and approval of this chapter, nor, in the discretion of the Department of Insurance, to any insurance company desiring to issue an underwriter's policy after the passage and approval of this chapter.

**44-357. Policies; stipulations forbidden.**

No insurance company shall issue in this state any policy or contract of insurance containing a provision, stipulation or agreement that such policy shall be construed according to the laws of any other state or country, or any provision limiting the time within which an action may be brought to less than the regular period of time prescribed by the statutes of limitations of this state, unless otherwise prescribed by this chapter.

**44-358. Policies; misrepresentations; warranties; conditions; effect.**

No oral or written misrepresentation or warranty made in the negotiation for a contract or policy of insurance by the insured, or in his behalf, shall be deemed material or defeat or avoid the policy, or prevent its attaching, unless such misrepresentation or warranty deceived the company to its injury. The breach of a warranty or condition in any contract or policy of insurance shall not avoid the policy nor avail the insurer to avoid liability, unless such breach shall exist at the time of the loss and contribute to the loss, anything in the policy or contract of insurance to the contrary notwithstanding.

**44-501. Fire insurance policies; form; contents.**

No policy or contract of fire and lightning insurance, including a renewal thereof, shall be made, issued, used, or delivered by any insurer or by any agent or representative thereof on property

within this state other than such as shall conform as nearly as practicable to blanks, size of type, context, provisions, agreements, and conditions with the 1943 Standard Fire Insurance Policy of the State of New York, a copy of which shall be filed in the office of the Director of Insurance as standard policy for this state, and no other or different provision, agreement, condition, or clause shall in any manner be made a part of such contract or policy or be endorsed thereon or delivered therewith except as provided in subdivisions (1) through (11) of this section.

(1) The name of the company, its location and place of business, the date of its incorporation or organization, the state or country under which such company is organized, the amount of paid-up capital stock, whether it is a stock, mutual, reciprocal, or assessment company, the names of its officers, the number and date of the policy, and appropriate company emblems may be printed on policies issued on property in this state. Any insurer organized under special charter provisions may so indicate upon its policy and may add a statement of the plan under which it operates in this state.

In lieu of the facsimile signatures of the president and secretary of the insurer on such policy, there may appear the signature or signatures of such persons as are duly authorized by the insurer to execute the contract. No such policy shall be void if the facsimile signature or signatures of any officer of the company shall not correspond with the actual persons who are such officers at the inception of the contract if such policy is countersigned by a duly authorized agent of the insurer.

(2) Printed or written forms of description and specifications or schedules of the property covered by any particular policy and any other matter necessary to express clearly all the facts and conditions of insurance on any particular risk, which facts or conditions shall in no case be inconsistent with or a waiver of any of the provisions or conditions of the standard policy herein provided for, may be written upon or attached or appended to any policy issued on property in this state. Appropriate forms of supplemental contracts, contracts, or endorsements, whereby the interest in the property described in such policy shall be insured against one or more of the perils which insurer is empowered to assume, may be used in connection with the standard policy. Such forms of contracts, supplemental contracts, or endorsements attached or printed thereon may contain provisions and stipulations inconsistent with the standard policy if applicable only to such other perils. The pages of the standard policy may be renumbered and rearranged for convenience in the preparation of individual contracts and to provide space for the listing of rates and premiums for coverages insured thereunder or under endorsements attached or printed thereon and such other data as may be included for duplication on daily reports for office records.

(3) A company, corporation, or association organized or incorporated under and in pursuance of the laws of this state or elsewhere, if entitled to do business in this state, may with the approval of the Director of Insurance, if the same is not already included in the standard form as filed in the office of the Department of Insurance, print on its policies any provision which it is required by law to insert therein if the provision is not in conflict with the laws of this state or the United States or with the provisions of the standard form provided for in this section, but such provision shall be printed apart from the other provisions, agreements, or conditions of

the policy and in type not smaller than the body of the policy and a separate title, as follows: Provisions required by law to be stated in this policy, and be a part of the policy.

(4) There may be endorsed on the outside of any policy provided for in this section for the name, with the word Agent or Agents and place of business, of any insurance agent or agents, either by writing, printing, stamping, or otherwise. There may also be added, with the approval of the Director of Insurance, a statement of the group of companies with which the company is financially affiliated and the usual company medallion.

(5) When two or more companies, each having previously complied with the laws of this state, unite to issue a joint policy, there may be expressed in the headline of each policy the fact of the severalty of the contract and also the proportion of premiums to be paid to each company and the proportion of liability which each company agrees to assume. In the printed conditions of such policy, the necessary change may be made from the singular to plural number when reference is made to the companies issuing such policy.

(6) This section shall not apply to motor vehicle, inland marine, nor ocean marine insurance nor shall it apply to reinsurance contracts between insurance companies. The Director of Insurance may approve any form of policy which includes coverage against the peril of fire and substantial coverage against other perils without complying with the provisions of this section if such policy with respect to the peril of fire includes provisions which are the substantial equivalent of the minimum provisions of the standard policy provided for in this section and if the policy is complete as to all its terms without reference to any other document.

(7) If the policy is made by a mutual assessment or other company having special regulations lawfully applicable to its organization, membership, policies, or contracts of insurance, such regulations shall apply to and form a part of the policy as the same may be written or printed upon or attached or appended thereto.

(8) Policies of assessment associations may be issued with such modifications as shall be approved in writing by the Department of Insurance.

(9) Any other coverage which a company is authorized to write under the laws of this state may be written in combination with a fire insurance policy.

(10) The policy shall provide that claims involving total loss situations shall be paid in accordance with section 44-501.02.

(11) The Director of Insurance may approve any form of policy with variations in terms and conditions from the standard policy provided for in this section.

#### **44-501.02. Fire insurance; valued policies.**

Whenever any policy of insurance is written to insure any real property in this state against loss by fire, tornado, windstorm, lightning, or explosion and the property insured is wholly destroyed without criminal fault on the part of the insured or his or her assignee, the amount of the insurance

written in such policy shall be taken conclusively to be the true value of the property insured and the true amount of loss and measure of damages.

**44-514. Automobile liability policy; terms, defined.**

For purposes of sections 44-514 to 44-521, unless the context otherwise requires:

(1) Policy shall mean an automobile liability policy providing all or part of the coverage defined in subdivision (2) of this section, delivered or issued for delivery in this state, insuring a natural person as named insured or one or more related individuals resident of the same household, and under which the insured vehicles designated in the policy are of the following types only:

(a) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers nor rented to others; or

(b) any other four-wheel motor vehicle of the pickup, panel, or delivery type which is not used in the occupation, profession, or business of the insured, except that sections 44-514 to 44-521 shall not apply

(i) to any policy issued under an automobile assigned-risk plan;

(ii) to any policy insuring more than four automobiles;

(iii) to any policy covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards; or

(iv) to any policy of insurance issued principally to cover personal or premises liability of an insured even though such insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance, or use of a motor vehicle on the premises of such insured or on the way immediately adjoining such premises;

(2) Automobile liability coverage shall include only coverage of bodily injury and property damage liability, medical payments, uninsured motorist coverage, and underinsured motorist coverage;

(3) Renewal or to renew shall mean the issuance and delivery by an insurer of a policy replacing at the end of the policy period a policy previously issued and delivered by the same insurer or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term, except that

(a) any policy with a policy period or term of less than six months shall be considered as if written for a policy period or term of six months and

(b) any policy written for a term longer than one year or any policy with no fixed expiration date shall be considered as if written for successive policy periods or terms of

one year, and such policy may be terminated at the expiration of any annual period upon giving twenty days' notice of cancellation prior to such anniversary date, and such cancellation shall not be subject to any other provisions of sections 44-514 to 44-521; and

(4) Nonpayment of premium shall mean failure of the named insured to discharge when due any of his or her obligations in connection with the payment of any premium on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

**44-515. Automobile liability policy; notice of cancellation; requirements; exceptions.**

(1) A notice of cancellation of a policy shall be effective only if it is based on one or more of the following reasons:

(a) Nonpayment of premium;

(b) Fraud or material misrepresentation affecting the policy or in the presentation of a claim thereunder, or violation of any of the terms or conditions of the policy; or

(c) The named insured or any operator, either resident in the same household or who customarily operates an automobile insured under the policy,

(i) has had his or her driver's license suspended or revoked pursuant to law,

(ii) has been convicted of larceny of an automobile, or theft of an automobile in violation of section 28-516,

(iii) has been convicted of an offense for which such suspension or revocation is mandatory, or

(iv) whose driver's license is subject to revocation or suspension pursuant to the provisions of sections 60-4,182 to 60-4,186, by reason of his or her driving record as disclosed by the files of the Director of Motor Vehicles during the policy period or, if the policy is a renewal, during its policy period or the one hundred eighty days immediately preceding its effective date.

(2) This section shall not apply to any policy or coverage which has been in effect less than sixty days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy.

(3) This section shall not apply to nonrenewal.

**44-516. Automobile liability policy; notice of cancellation; reason for cancellation.**

(1) No notice of cancellation of a policy to which section 44-515 applies shall be effective unless mailed by registered or certified mail to the named insured at least thirty days prior to

the effective date of cancellation, except that if cancellation is for nonpayment of premium, at least ten days' notice of cancellation accompanied by the reason therefor shall be given. The requirements of this subsection shall apply to a cancellation initiated by a premium finance company for nonpayment of premium. Unless the reason accompanies or is included in the notice of cancellation, the notice of cancellation shall state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer not less than twenty-five days prior to the effective date of cancellation, the insurer will specify the reason for such cancellation.

(2) The insurer shall, upon such written request of the named insured, mailed or delivered to the insurer not less than twenty-five days prior to the effective date of cancellation, specify in writing the reason for such cancellation. Such reason shall be mailed or delivered to the named insured within five days after receipt of such request.

(3) This section shall not apply to nonrenewal.

**44-517. Automobile liability policy; notice of intention not to renew; requirements.**

No insurer shall refuse to renew a policy unless such insurer or its agent shall mail or deliver to the named insured, at the address shown in the policy, at least twenty days' advance notice of its intention not to renew. This section shall not apply:

(1) If the insurer has manifested its willingness to renew; nor

(2) in case of nonpayment of premium; PROVIDED, notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies.

Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

**44-518. Automobile liability policy; notice of intention not to renew; reason.**

If an insurer shall refuse to renew a policy, as provided for in section 44-517, the insurer shall, upon written request of the named insured, mailed or delivered not less than fifteen days prior to the effective date of such notice of intention not to renew, specify in writing the reason for such refusal to renew. Such reason shall be mailed or delivered to the named insured within five days after receipt of such request.

**44-520. Automobile liability policy; cancellation; notice of other insurance; contents.**

When automobile bodily injury and property damage liability coverage is canceled, other than for nonpayment of premium, or in the event of failure to renew automobile bodily injury and property damage liability coverage to which section 44-517 applies, the insurer shall notify the named insured of his possible eligibility for automobile liability insurance through an affiliated insurer or

the automobile liability assigned-risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew.

**44-521. Automobile liability policy; no liability on director or others furnishing information.**

There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Director of Insurance or against any insurer, its authorized representative, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or intention not to renew, for any statement made by any of them in any written notice of cancellation or intention not to renew, or in any other communication, oral or written, specifying the reasons for cancellation or intention not to renew, or the providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

**44-522. Policies; cancellation requirements.**

(1) The Department of Insurance shall not approve any insurance policy filed for approval with the department, as required by the Property and Casualty Insurance Rate and Form Act, which insures against loss or damage to property or against legal liability from any cause unless such policy contains appropriate provisions for cancellation thereof by either the insurer or the insured and for nonrenewal thereof by the insurer.

(2) On any policy or binder of property, marine, or liability insurance, as specified in section 44-201, the insurer shall give the insured sixty days' written notice prior to cancellation or nonrenewal of such policy or binder, except that the insurer may cancel upon ten days' written notice to the insured in the event of nonpayment of premium or if such policy or binder has a specified term of sixty days or less unless the policy or binder has previously been renewed. The requirements of this subsection shall apply to a cancellation initiated by a premium finance company for nonpayment of premium. The provisions of this subsection and subsection (4) of this section shall not apply to nonrenewal of a policy or binder which has a specified term of sixty days or less unless the policy or binder has previously been renewed. Such notice shall state the reason for cancellation or nonrenewal.

(3) Notwithstanding subsection (2) of this section, no policy of property, marine, or liability insurance, as specified in section 44-201, which has been in effect for more than sixty days shall be canceled by the insurer except for one of the following reasons:

- (a) Nonpayment of premium;
- (b) The policy was obtained through a material misrepresentation;
- (c) Any insured has submitted a fraudulent claim;
- (d) Any insured has violated any of the terms and conditions of the policy;

- (e) The risk originally accepted has substantially increased;
  - (f) Certification to the Director of Insurance of loss of reinsurance by the insurer which provided coverage to the insurer for all or a substantial part of the underlying risk insured; or
  - (g) The determination by the director that the continuation of the policy could place the insurer in violation of the insurance laws of this state.
- (4) Notice of cancellation or nonrenewal shall be sent by registered, certified, or first-class mail to the insured's last mailing address known to the insurer. If sent by first-class mail, a United States Postal Service certificate of mailing shall be sufficient proof of receipt of notice on the third calendar day after the date of the certificate.
- (5) For purposes of this section:
- (a) An insurer's substitution of insurance upon renewal which results in substantially equivalent coverage shall not be considered a cancellation of or a refusal to renew a policy; and
  - (b) The transfer of a policyholder between insurers within the same insurance group shall be considered a cancellation or a refusal to renew a policy only if the transfer results in policy coverage or rates substantially less favorable to the insured.
- (6) The requirements of subsections (2), (3), and (4) of this section shall not apply to automobile insurance coverage, insurance coverage issued under the Nebraska Workers' Compensation Act, insurance coverage on growing crops, or insurance coverage which is for a specified season or event and which is not subject to renewal or replacement.
- (7) All policy forms issued for delivery in Nebraska shall conform to this section.

**44-523. Automobile liability insurance policy; cancellation; notice; exceptions.**

- (1) (a) Except as provided in subdivision (1)(b) of this section, a notice of cancellation, given for reasons other than for nonpayment of premium, of a policy of automobile liability insurance issued or delivered in this state shall only be effective if mailed by registered or certified mail to the named insured at the address shown in the policy at least thirty days prior to the effective date of such cancellation.
- (b) A notice of cancellation, initiated by a premium finance company, of a policy of automobile liability insurance issued or delivered in this state shall only be effective if mailed by registered or certified mail to the named insured at the address shown in the policy at least ten days prior to the effective date of such cancellation.

(2) This section shall not apply

(a) to any policy subject to sections 44-514 to 44-521,

(b) to any policy issued under an automobile assigned-risk plan or to any policy of insurance issued principally to cover personal or premises liability of an insured even though such insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance, or use of a motor vehicle on the premises of the insured or on the ways adjoining such premises, and

(c) to any policy or coverage which has been in effect less than sixty days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy.

(3) Any attempted cancellation in violation of the provisions of this section shall be void.

**44-601. Over-insurance; policies for more than five years prohibited.**

It shall be unlawful for any insurance company or any agent to knowingly issue any fire insurance policy upon property within this state for an amount which, with any existing insurance, exceeds the fair value of the property or of the interest of the insured therein, or for a longer time than for five years, except as provided in section 44-812.

**44-6408. Motor vehicle liability policy; uninsured and underinsured motor vehicle insurance coverages; when required.**

(1) No policy insuring against liability imposed by law for bodily injury, sickness, disease, or death suffered by a natural person arising out of the ownership, operation, maintenance, or use of a motor vehicle within the United States, its territories or possessions, or Canada shall be delivered, issued for delivery, or renewed with respect to any motor vehicle principally garaged in this state unless coverage is provided for the protection of persons insured who are legally entitled to recover compensatory damages for bodily injury, sickness, disease, or death from

(a) the owner or operator of an uninsured motor vehicle in limits of twenty-five thousand dollars because of bodily injury, sickness, disease, or death of one person in any one accident and, subject to such limit for one person, fifty thousand dollars because of bodily injury, sickness, disease, or death of two or more persons in any one accident, and

(b) the owner or operator of an underinsured motor vehicle in limits of twenty-five thousand dollars because of bodily injury, sickness, disease, or death of one person in any one accident and, subject to such limit for one person, fifty thousand dollars because of bodily injury, sickness, disease, or death of two or more persons in any one accident.

(2) At the written request of the named insured, the insurer shall provide higher limits of uninsured and underinsured motorist coverages in accordance with its rating plan and rules,

except that in no event shall the insurer be required to provide limits higher than one hundred thousand dollars per person and three hundred thousand dollars per accident.

(3) After purchase of uninsured and underinsured motorist coverages, no insurer or any affiliated insurer shall be required to notify any policyholder in any renewal, reinstatement, substitute, amended, altered, modified, transfer, or replacement policy as to the availability of optional limits of such coverages. The named insured may, subject to the limitations of this section, make a written request for additional coverage or coverage more extensive than that provided in a prior policy.